



House of Representatives

File No. 680

General Assembly

February Session, 2004 **(Reprint of File No. 504)**

Substitute House Bill No. 5669
As Amended by House
Amendment Schedules "A" and "D"

Approved by the Legislative Commissioner
April 28, 2004

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective from passage*) (a) All civil actions brought
2 to recover damages resulting from personal injury or wrongful death,
3 whether in tort or in contract, in which it is alleged that such injury or
4 death resulted from the negligence of a health care provider, as
5 defined in section 52-184b of the general statutes, shall be referred to
6 mandatory mediation pursuant to this section, unless the parties have
7 agreed to refer the civil action to an alternative dispute resolution
8 program.

9 (b) The purpose of such mandatory mediation shall be to (1) review
10 the certificate of good faith filed pursuant to section 52-190a of the
11 general statutes, as amended by this act, to determine whether there
12 are grounds for a good faith belief that the defendant has been
13 negligent in the care or treatment of the claimant, (2) attempt to
14 achieve a prompt settlement or resolution of the case, and (3) expedite
15 the litigation of the case.

16 (c) Upon the filing of the answer in such action by the defendant,
17 the clerk of the court for the judicial district in which the case is
18 pending shall refer the case to a judge of the superior court for
19 mediation. The mediation shall commence as soon as practicable, but
20 not later than thirty days after the filing of the answer. The mediation
21 shall not stay or delay the prosecution of the case, nor delay discovery
22 in or the trial of the case.

23 (d) At the mediation, the court shall review the certificate of good
24 faith filed pursuant to section 52-190a of the general statutes, as
25 amended by this act, to determine whether there are grounds for a
26 good faith belief that the defendant has been negligent in the care or
27 treatment of the claimant. If the court determines that the certificate of
28 good faith is inadequate to permit such a determination, it may order
29 the party submitting the certificate to file, within thirty days, a
30 supplemental certificate setting forth the grounds for the opinion that
31 there has been negligence in the care or treatment of the claimant.

32 (e) If the court determines that the certificate of good faith or any
33 supplemental certificate is inadequate to support a determination that
34 there are grounds for a good faith belief that there has been negligence
35 in the care or treatment of the claimant, it shall order the party
36 asserting such a claim to post a cash or surety bond in the amount of
37 five thousand dollars as a condition of continuing the prosecution of
38 the case, which bond shall be used to pay the taxable costs of the other
39 party, as permitted by the general statutes, in the event of the
40 unsuccessful prosecution of the case.

41 (f) All parties to the case, together with a representative of each
42 insurer that may be liable to pay all or part of any verdict or settlement
43 in the case, shall attend the mediation in person, unless attendance by
44 means of telephone is permitted upon written agreement of all parties
45 or written order of the court.

46 (g) If the mediation does not settle or conclude the case, the court
47 shall enter such orders as are necessary to narrow the issues, expedite

48 discovery and assist the parties in preparing the case for trial.

49 Sec. 2. Section 52-190a of the general statutes, as amended by section
50 14 of public act 03-202, is repealed and the following is substituted in
51 lieu thereof (*Effective from passage and applicable to actions filed on or after*
52 *said date*):

53 (a) No civil action or apportionment complaint shall be filed to
54 recover damages resulting from personal injury or wrongful death
55 occurring on or after October 1, 1987, whether in tort or in contract, in
56 which it is alleged that such injury or death resulted from the
57 negligence of a health care provider, unless the attorney or party filing
58 the action or apportionment complaint has made a reasonable inquiry
59 as permitted by the circumstances to determine that there are grounds
60 for a good faith belief that there has been negligence in the care or
61 treatment of the claimant. The complaint, [or] initial pleading or
62 apportionment complaint shall contain a certificate of the attorney or
63 party filing the action or apportionment complaint that such
64 reasonable inquiry gave rise to a good faith belief that grounds exist
65 for an action against each named defendant or for an apportionment
66 complaint against each named apportionment defendant. [For the
67 purposes of this section, such good faith may be shown to exist if the
68 claimant or his attorney has received a written opinion, which shall not
69 be subject to discovery by any party except for questioning the validity
70 of the certificate,] To show the existence of such good faith, the
71 claimant or such claimant's attorney, and any apportionment
72 complainant or such apportionment complainant's attorney, shall
73 obtain a written and signed opinion of a similar health care provider,
74 as defined in section 52-184c, which similar health care provider shall
75 be selected pursuant to the provisions of said section, that there
76 appears to be evidence of medical negligence and includes a detailed
77 basis for the formation of such opinion. Such written opinion shall not
78 be subject to discovery by any party except for questioning the validity
79 of the certificate. The claimant or such claimant's attorney, and any
80 apportionment complainant or such apportionment complainant's
81 attorney, shall retain the original written opinion and shall attach a

82 copy of such written opinion, with the name and signature of the
83 similar health care provider expunged, to such certificate. The similar
84 health care provider who provides such written opinion shall not,
85 without a showing of malice, be personally liable for any damages to
86 the defendant health care provider by reason of having provided such
87 written opinion. In addition to such written opinion, the court may
88 consider other factors with regard to the existence of good faith. If the
89 court determines, after the completion of discovery, that such
90 certificate was not made in good faith and that no justiciable issue was
91 presented against a health care provider that fully cooperated in
92 providing informal discovery, the court upon motion or upon its own
93 initiative shall impose upon the person who signed such certificate or a
94 represented party, or both, an appropriate sanction which may include
95 an order to pay to the other party or parties the amount of the
96 reasonable expenses incurred because of the filing of the pleading,
97 motion or other paper, including a reasonable attorney's fee. The court
98 may also submit the matter to the appropriate authority for
99 disciplinary review of the attorney if the claimant's attorney or
100 apportionment complainant's attorney submitted the certificate.

101 (b) If a claimant in a civil action asserts a claim against an
102 apportionment defendant pursuant to subsection (d) of section 52-
103 102b, the requirement under subsection (a) of this section that the
104 attorney or party filing the action make a reasonable inquiry and
105 submit a certificate of good faith shall be satisfied by the submission of
106 a certificate of good faith by the apportionment complainant pursuant
107 to subsection (a) of this section.

108 ~~[(b)]~~ (c) Upon petition to the clerk of the court where the action will
109 be filed, an automatic ninety-day extension of the statute of limitations
110 shall be granted to allow the reasonable inquiry required by subsection
111 (a) of this section. This period shall be in addition to other tolling
112 periods.

113 Sec. 3. Section 19a-17a of the general statutes is repealed and the
114 following is substituted in lieu thereof (*Effective from passage*):

115 (a) Upon the filing of any civil action regarding a medical
116 malpractice claim against an individual licensed pursuant to chapter
117 370 to 373, inclusive, 375, 379, 380 or 383, the plaintiff or the plaintiff's
118 attorney shall mail a copy of the complaint to the Department of Public
119 Health and the Insurance Department. Receipt or review of a copy of a
120 complaint submitted pursuant to this subsection shall not be
121 considered an investigation of such individual licensee by the
122 Department of Public Health or any examining board.

123 (b) Upon entry of any medical malpractice award by a court or upon
124 the parties entering a settlement of a malpractice claim against an
125 individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379,
126 380 or 383, the entity making payment on behalf of a party or, if no
127 such entity exists, the party, shall [notify] provide to the Department of
128 Public Health and the Insurance Department notice of the terms of the
129 award or settlement and [shall provide to the department] a copy of
130 the award or settlement and the underlying complaint and answer, if
131 any. Such notice and copies provided to the Insurance Department
132 shall not identify the parties to the claim. The Department of Public
133 Health shall send the information received from such entity or party to
134 the state board of examiners having cognizance over any individual
135 licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383
136 who is a party to the claim. The [department] Department of Public
137 Health shall review all medical malpractice complaints, awards and
138 [all] settlements to determine whether further investigation or
139 disciplinary action against the providers involved is warranted. On
140 and after October 1, 2004, such review shall be conducted in
141 accordance with the guidelines adopted by the Department of Public
142 Health, in accordance with section 20-13b, as amended by this act, to
143 determine the basis for such further investigation or disciplinary
144 action. Any document received pursuant to this section shall not be
145 considered a petition and shall not be subject to [the provisions of]
146 disclosure under section 1-210, as amended, unless the [department]
147 Department of Public Health determines, following completion of its
148 review, that further investigation or disciplinary action is warranted.

149 As used in this subsection, "terms of the award or settlement" means
150 the rights and obligations of the parties to a medical malpractice claim,
151 as determined by a court or by agreement of the parties, and includes,
152 but is not limited to, (1) for any individual licensed pursuant to chapter
153 370 to 373, inclusive, 375, 379, 380 or 383 who is a party to the claim,
154 the type of healing art or other health care practice, and the specialty, if
155 any, in which such individual engages, (2) the amount of the award or
156 settlement, specifying the portion of the award or settlement
157 attributable to economic damages, the portion of the award or
158 settlement attributable, if determined by the parties, to noneconomic
159 damages, and, if an award was entered, the portion of the award, if
160 any, attributable to interest awarded pursuant to section 52-192a, as
161 amended by this act, and (3) if there are multiple defendants, the
162 allocation for payment of the award or settlement between or among
163 such defendants.

164 (c) No release of liability executed by a party to which payment is to
165 be made under a settlement of a malpractice claim against an
166 individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379,
167 380 or 383 shall be effective until the attorney for the entity making
168 payment on behalf of a party or, if no such entity exists, the attorney
169 for the party, files with the court an affidavit stating that such attorney
170 has provided the information required under subsection (b) of this
171 section to the Department of Public Health and the Insurance
172 Department.

173 (d) The Commissioner of Public Health and the Insurance
174 Commissioner shall each develop a system within the commissioner's
175 respective agency for collecting, storing, utilizing, interpreting,
176 reporting and providing public access to the information received
177 under subsections (a) and (b) of this section. Each commissioner shall
178 report the details of such system with respect to the commissioner's
179 agency to the joint standing committees of the General Assembly
180 having cognizance of matters relating to public health and insurance
181 on or before October 1, 2004, in accordance with section 11-4a.

182 Sec. 4. Section 20-13b of the general statutes is repealed and the
183 following is substituted in lieu thereof (*Effective from passage*):

184 The Commissioner of Public Health, with advice and assistance
185 from the board, may establish such regulations in accordance with
186 chapter 54 as may be necessary to carry out the provisions of sections
187 20-13a to 20-13i, inclusive, as amended by this act. On or before July 1,
188 2004, such regulations shall include, but need not be limited to: (1)
189 Guidelines for screening complaints received to determine which
190 complaints will be investigated; (2) guidelines to provide a basis for
191 prioritizing the order in which complaints will be investigated; (3) a
192 system for conducting investigations to ensure prompt action when it
193 appears necessary; (4) guidelines to determine when an investigation
194 should be broadened beyond the initial complaint to include sampling
195 patient records to identify patterns of care, reviewing office practices
196 and procedures, reviewing performance and discharge data from
197 hospitals and managed care organizations and conducting additional
198 interviews of patients; and (5) guidelines to protect and ensure the
199 confidentiality of patient and provider identifiable information when
200 an investigation is broadened beyond the initial complaint.

201 Sec. 5. Section 20-8a of the general statutes is repealed and the
202 following is substituted in lieu thereof (*Effective from passage*):

203 (a) There shall be within the Department of Public Health a
204 Connecticut Medical Examining Board. Said board shall consist of
205 fifteen members appointed by the Governor, subject to the provisions
206 of section 4-9a, as amended, in the manner prescribed for department
207 heads in section 4-7, as follows: Five physicians practicing in the state;
208 one physician who shall be a full-time member of the faculty of The
209 University of Connecticut School of Medicine; one physician who shall
210 be a full-time chief of staff in a general-care hospital in the state; one
211 physician who shall be registered as a supervising physician for one or
212 more physician assistants; one physician who shall be a graduate of a
213 medical education program accredited by the American Osteopathic
214 Association; one physician assistant licensed pursuant to section

215 20-12b and practicing in this state; and five public members. No
216 professional member of said board shall be an elected or appointed
217 officer of a professional society or association relating to such
218 member's profession at the time of appointment to the board or have
219 been such an officer during the year immediately preceding
220 appointment or serve for more than two consecutive terms.
221 Professional members shall be practitioners in good professional
222 standing and residents of this state.

223 (b) All vacancies shall be filled by the Governor in the manner
224 prescribed for department heads in section 4-7. Successors and
225 appointments to fill a vacancy shall fulfill the same qualifications as
226 the member succeeded or replaced. In addition to the requirements in
227 sections 4-9a, as amended, and 19a-8, no person whose spouse, parent,
228 brother, sister, child or spouse of a child is a physician, as defined in
229 section 20-13a, or a physician assistant, as defined in section 20-12a,
230 shall be appointed as a public member.

231 (c) The Commissioner of Public Health shall establish a list of
232 eighteen persons who may serve as members of medical hearing
233 panels established pursuant to [subsection (g) of] this section. Persons
234 appointed to the list shall serve as members of the medical hearing
235 panels and provide the same services as members of the Connecticut
236 Medical Examining Board. Members from the list serving on such
237 panels shall not be voting members of the Connecticut Medical
238 Examining Board. The list shall consist of eighteen members appointed
239 by the commissioner, eight of whom shall be physicians, as defined in
240 section 20-13a, with at least one of such physicians being a graduate of
241 a medical education program accredited by the American Osteopathic
242 Association, one of whom shall be a physician assistant licensed
243 pursuant to section 20-12b, and nine of whom shall be members of the
244 public. No professional member of the list shall be an elected or
245 appointed officer of a professional society or association relating to
246 such member's profession at the time of appointment to the list or have
247 been such an officer during the year immediately preceding such
248 appointment to the list. A licensed professional appointed to the list

249 shall be a practitioner in good professional standing and a resident of
250 this state. All vacancies shall be filled by the commissioner. Successors
251 and appointments to fill a vacancy on the list shall possess the same
252 qualifications as those required of the member succeeded or replaced.
253 No person whose spouse, parent, brother, sister, child or spouse of a
254 child is a physician, as defined in section 20-13a, or a physician
255 assistant, as defined in section 20-12a, shall be appointed to the list as a
256 member of the public. Each person appointed to the list shall serve
257 without compensation at the pleasure of the commissioner. Each
258 medical hearing panel shall consist of three members, one of whom
259 shall be a similar health care provider, as defined in section 52-184c, to
260 the person who is the subject of the complaint, and two of whom shall
261 be public members. At least one of the three members shall be a
262 member of the Connecticut Medical Examining Board. The public
263 members may be a member of the board or a member from the list
264 established pursuant to this subsection.

265 (d) The office of the board shall be in Hartford, in facilities to be
266 provided by the department.

267 (e) The board shall adopt and may amend a seal.

268 (f) The Governor shall appoint a chairperson from among the board
269 members. Said board shall meet at least once during each calendar
270 quarter and at such other times as the chairperson deems necessary.
271 Special meetings shall be held on the request of a majority of the board
272 after notice in accordance with the provisions of section 1-225. A
273 majority of the members of the board shall constitute a quorum.
274 Members shall not be compensated for their services. Any member
275 who fails to attend three consecutive meetings or who fails to attend
276 fifty per cent of all meetings held during any calendar year shall be
277 deemed to have resigned from office. Minutes of all meetings shall be
278 recorded by the board. No member shall participate in the affairs of
279 the board during the pendency of any disciplinary proceedings by the
280 board against such member. Said board shall (1) hear and decide
281 matters concerning suspension or revocation of licensure, (2)

282 adjudicate complaints against practitioners, and (3) impose sanctions
283 where appropriate.

284 (g) (1) Not later than July 1, 2004, the board, with the assistance of
285 the department, shall adopt regulations, in accordance with chapter 54,
286 to establish guidelines for use in the disciplinary process. Such
287 guidelines shall include, but need not be limited to: (A) Identification
288 of each type of violation; (B) a range of penalties for each type of
289 violation; (C) additional optional conditions that may be imposed by
290 the board for each violation; (D) identification of factors the board shall
291 consider in determining what penalty should apply; (E) conditions,
292 such as mitigating factors or other facts, that may be considered in
293 allowing deviations from the guidelines; and (F) a provision that when
294 a deviation from the guidelines occurs, the reason for the deviation
295 shall be identified.

296 (2) The board shall refer all statements of charges filed with the
297 board by the department pursuant to section 20-13e, as amended by
298 this act, to a medical hearing panel [within] not later than sixty days
299 [of] after the receipt of charges. [This] The time period may be
300 extended for good cause by the board in a duly recorded vote. [The
301 panel shall consist of three members, at least one of whom shall be a
302 member of the board and one a member of the public. The public
303 member may be a member of either the board or of the list established
304 pursuant to subsection (c) of this section.] The panel shall conduct a
305 hearing, in accordance with the provisions of chapter 54, and the
306 regulations [established] adopted by the Commissioner of Public
307 Health concerning contested cases, except that the panel shall file a
308 proposed final decision with the board [within] not later than one
309 hundred twenty days [of] after the receipt of the issuance of the notice
310 of hearing by the board. The time period for filing such proposed final
311 decision with the board may be extended for good cause by the board
312 in a duly recorded vote. If the panel does not conduct a hearing within
313 sixty days of the date of referral of the statement of charges by the
314 board, the commissioner shall conduct a hearing in accordance with
315 chapter 54 and the regulations adopted by the commissioner

316 concerning contested cases. The commissioner shall file a proposed
317 final decision with the board not later than sixty days after such
318 hearing, except that the time period for filing such proposed final
319 decision with the board may be extended for good cause by the board
320 in a duly recorded vote.

321 (h) The board shall review the panel's proposed final decision in
322 accordance with the provisions of section 4-179, and adopt, modify or
323 remand said decision for further review or for the taking of additional
324 evidence. The board shall act on the proposed final decision within
325 ninety days of the filing of said decision by the panel. [This] The time
326 period may be extended by the board for good cause in a duly
327 recorded vote.

328 (i) Except in a case in which a license has been summarily
329 suspended, pursuant to subsection (c) of section 19a-17 or subsection
330 (c) of section 4-182, all three panel members shall be present to hear
331 any evidence and vote on a proposed final decision. The chairperson of
332 the Medical Examining Board may exempt a member from a meeting
333 of the panel if the chairperson finds that good cause exists for such an
334 exemption. Such an exemption may be granted orally but shall be
335 reduced to writing and included as part of the record of the panel
336 within two business days of the granting of the exemption or the
337 opening of the record and shall state the reason for the exemption.
338 Such exemption shall be granted to a member no more than once
339 during any contested case and shall not be granted for a meeting at
340 which the panel is acting on a proposed final decision on a statement
341 of charges. The board may appoint a member to the panel to replace
342 any member who resigns or otherwise fails to continue to serve on the
343 panel. Such replacement member shall review the record prior to the
344 next hearing.

345 (j) A determination of good cause shall not be reviewable and shall
346 not constitute a basis for appeal of the decision of the board pursuant
347 to section 4-183.

348 Sec. 6. Section 20-13i of the general statutes is repealed and the
349 following is substituted in lieu thereof (*Effective from passage*):

350 The department shall file with the Governor and the joint standing
351 committee on public health of the General Assembly on or before
352 January 1, 1986, and thereafter on or before January first of each
353 succeeding year, a report of the activities of the department and the
354 board conducted pursuant to sections 20-13d and 20-13e, as amended
355 by this act. Each such report shall include, but shall not be limited to,
356 the following information: The number of petitions received; the
357 number of petitions not investigated, and the reasons why; the number
358 of hearings held on such petitions; [and,] the outcome of such
359 hearings; the timeliness of action taken on any petition considered to
360 be a priority; without identifying the particular physician concerned, a
361 brief description of the impairment alleged in each such petition and
362 the actions taken with regard to each such petition by the department
363 and the board; the number of notifications received pursuant to section
364 19a-17a, as amended by this act; the number of such notifications with
365 no further action taken, and the reasons why; and the outcomes for
366 notifications where further action is taken.

367 Sec. 7. (NEW) (*Effective from passage*) (a) The Department of Public
368 Health shall develop protocols for accurate identification procedures
369 that shall be used by hospitals and outpatient surgical facilities prior to
370 surgery. Such protocols shall include, but need not be limited to, (1)
371 procedures to be followed to identify the (A) patient, (B) surgical
372 procedure to be performed, and (C) body part on which the surgical
373 procedure is to be performed, and (2) alternative identification
374 procedures in urgent or emergency circumstances or where the patient
375 is nonspeaking, comatose or incompetent or is a child. After October 1,
376 2004, no hospital or outpatient surgical facility may anesthetize a
377 patient or perform surgery unless the protocols have been followed.

378 (b) Not later than October 1, 2004, the department shall report, in
379 accordance with section 11-4a of the general statutes, to the joint
380 standing committee of the General Assembly having cognizance of

381 matters relating to public health describing the protocols developed
382 pursuant to subsection (a) of this section.

383 Sec. 8. Section 52-192a of the general statutes is repealed and the
384 following is substituted in lieu thereof (*Effective from passage*):

385 (a) After commencement of any civil action based upon contract or
386 seeking the recovery of money damages, whether or not other relief is
387 sought, the plaintiff may, not later than thirty days before trial, file
388 with the clerk of the court a written "offer of judgment" signed by the
389 plaintiff or the plaintiff's attorney, directed to the defendant or the
390 defendant's attorney, offering to settle the claim underlying the action
391 and to stipulate to a judgment for a sum certain. The plaintiff shall give
392 notice of the offer of settlement to the defendant's attorney or, if the
393 defendant is not represented by an attorney, to the defendant himself
394 or herself. Within sixty days after being notified of the filing of the
395 "offer of judgment" or within any extension or extensions thereof, not
396 to exceed a total of one hundred twenty additional days, granted by
397 the court for good cause shown not later than the expiration of such
398 sixty-day period or any extension thereof, and prior to the rendering of
399 a verdict by the jury or an award by the court, the defendant or the
400 defendant's attorney may file with the clerk of the court a written
401 "acceptance of offer of judgment" agreeing to a stipulation for
402 judgment as contained in plaintiff's "offer of judgment". Upon such
403 filing, the clerk shall enter judgment immediately on the stipulation. If
404 the "offer of judgment" is not accepted within [sixty days] the sixty-day
405 period or any extension thereof, and prior to the rendering of a verdict
406 by the jury or an award by the court, the "offer of judgment" shall be
407 considered rejected and not subject to acceptance unless refiled. Any
408 such "offer of judgment" and any "acceptance of offer of judgment"
409 shall be included by the clerk in the record of the case.

410 (b) After trial the court shall examine the record to determine
411 whether the plaintiff made an "offer of judgment" which the defendant
412 failed to accept. [If] Except with respect to a civil action described in
413 subsection (c) of this section, if the court ascertains from the record that

414 the plaintiff has recovered an amount equal to or greater than the sum
415 certain stated in the plaintiff's "offer of judgment", the court shall add
416 to the amount so recovered twelve per cent annual interest on said
417 amount. [, computed from the date such offer was filed in actions
418 commenced before October 1, 1981. In those actions commenced on or
419 after October 1, 1981, the]

420 (c) With respect to any civil action brought to recover damages
421 resulting from personal injury or wrongful death, whether in tort or in
422 contract, in which it is alleged that such injury or death resulted from
423 the negligence of a health care provider, as defined in section 52-184b,
424 and where the cause of action accrued on or after the effective date of
425 this section, if the court ascertains from the record that the plaintiff has
426 recovered an amount equal to or greater than the sum certain stated in
427 the plaintiff's offer of judgment, the court shall add to the amount so
428 recovered eight per cent annual interest on said amount, except that if
429 the plaintiff has recovered an amount that is more than twice the sum
430 certain stated in the plaintiff's offer of judgment, the court shall add to
431 the amount so recovered (1) eight per cent annual interest on the
432 portion of the amount recovered that is equal to or less than twice the
433 sum certain stated in such offer of judgment, and (2) four per cent
434 annual interest on the portion of the amount recovered that is more
435 than twice the sum certain stated in such offer.

436 (d) The interest shall be computed from the date the complaint in
437 the civil action was filed with the court if the "offer of judgment" was
438 filed not later than eighteen months from the filing of such complaint.
439 If such offer was filed later than eighteen months from the date of
440 filing of the complaint, the interest shall be computed from the date the
441 "offer of judgment" was filed. The court may award reasonable
442 attorney's fees in an amount not to exceed three hundred fifty dollars,
443 and shall render judgment accordingly. This section shall not be
444 interpreted to abrogate the contractual rights of any party concerning
445 the recovery of attorney's fees in accordance with the provisions of any
446 written contract between the parties to the action.

447 Sec. 9. Section 52-194 of the general statutes is repealed and the
448 following is substituted in lieu thereof (*Effective from passage*):

449 In any action, the plaintiff may, within [ten] sixty days after being
450 notified by the defendant of the filing of an offer of judgment, or
451 within any extension or extensions thereof, not to exceed a total of one
452 hundred twenty additional days, granted by the court for good cause
453 shown not later than the expiration of such sixty-day period or any
454 extension thereof, file with the clerk of the court a written acceptance
455 of the offer signed by [himself or his] the plaintiff or the plaintiff's
456 attorney. Upon the filing of the written acceptance, the court shall
457 render judgment against the defendant as upon default for the sum so
458 named and for the costs accrued at the time of the defendant's giving
459 the plaintiff notice of the offer. No trial may be postponed because the
460 period within which the plaintiff may accept the offer has not expired,
461 except at the discretion of the court.

462 Sec. 10. Subsection (a) of section 20-13e of the general statutes is
463 repealed and the following is substituted in lieu thereof (*Effective from*
464 *passage*):

465 (a) (1) The department shall investigate each petition filed pursuant
466 to section 20-13d, in accordance with the provisions of subdivision (10)
467 of subsection (a) of section 19a-14, to determine if probable cause exists
468 to issue a statement of charges and to institute proceedings against the
469 physician under subsection (e) of this section. Such investigation shall
470 be concluded not later than eighteen months from the date the petition
471 is filed with the department and, unless otherwise specified by this
472 subsection, the record of such investigation shall be deemed a public
473 record, in accordance with section 1-210, as amended, at the conclusion
474 of such eighteen-month period. Any such investigation shall be
475 confidential and no person shall disclose his knowledge of such
476 investigation to a third party unless the physician requests that such
477 investigation and disclosure be open. If the department determines
478 that probable cause exists to issue a statement of charges, the entire
479 record of such proceeding shall be public unless the department

480 determines that the physician is an appropriate candidate for
481 participation in a rehabilitation program in accordance with subsection
482 (b) of this section and the physician agrees to participate in such
483 program in accordance with terms agreed upon by the department and
484 the physician. If at any time subsequent to the filing of a petition and
485 during the eighteen-month period, the department makes a finding of
486 no probable cause, the petition and the entire record of such
487 investigation shall remain confidential unless the physician requests
488 that such petition and record be open.

489 (2) If the department makes a finding of no probable cause, it shall
490 notify the person who filed the petition or such person's personal
491 representative and the physician of such finding and the reasons
492 therefor.

493 Sec. 11. Subsection (b) of section 19a-88 of the general statutes is
494 repealed and the following is substituted in lieu thereof (*Effective from*
495 *passage*):

496 (b) Each person holding a license to practice medicine, surgery,
497 podiatry, chiropractic or natureopathy shall, annually, during the
498 month of such person's birth, register with the Department of Public
499 Health, upon payment of the professional services fee for class I, as
500 defined in section 33-182l, on blanks to be furnished by the department
501 for such purpose, giving such person's name in full, such person's
502 residence and business address, the name of the insurance company
503 providing such person's professional liability insurance and the policy
504 number of such insurance, such person's area of specialization,
505 whether such person is actively involved in patient care, any
506 disciplinary action against such person, or malpractice payments made
507 on behalf of such person in any other state or jurisdiction, and such
508 other information as the department requests. The department may
509 compare information submitted pursuant to this subsection to
510 information contained in the National Practitioner Data Base. Persons
511 may fulfill their obligation to report the information required by this
512 subsection by submitting such information as part of their physician

513 profile, in accordance with section 20-13j. The department shall revise
514 any forms utilized pursuant to section 20-13j to incorporate any
515 additional information required pursuant to this subsection.

516 Sec. 12. (NEW) (*Effective from passage*) On or before January 1, 2005,
517 and annually thereafter, the Department of Public Health shall report,
518 in accordance with section 11-4a of the general statutes, the number of
519 physicians by specialty who are actively providing patient care.

520 Sec. 13. Section 38a-676 of the general statutes is repealed and the
521 following is substituted in lieu thereof (*Effective from passage*):

522 (a) With respect to rates pertaining to commercial risk insurance,
523 and subject to the provisions of subsection (b) of this section with
524 respect to professional liability insurance described in subsection (b) of
525 this section and workers' compensation and employers' liability
526 insurance, on or before the effective date [thereof, every] of such rates,
527 each admitted insurer shall submit to the Insurance Commissioner for
528 the commissioner's information, except as to inland marine risks which
529 by general custom of the business are not written according to manual
530 rates or rating plans, [every] each manual of classifications, rules and
531 rates, and [every] each minimum, class rate, rating plan, rating
532 schedule and rating system and any modification of the foregoing
533 which it uses. Such submission by a licensed rating organization of
534 which an insurer is a member or subscriber shall be sufficient
535 compliance with this section for any insurer maintaining membership
536 or subscribership in such organization, to the extent that the insurer
537 uses the manuals, minimums, class rates, rating plans, rating
538 schedules, rating systems, policy or bond forms of such organization.
539 The information shall be open to public inspection after its submission.

540 (b) (1) Each filing as described in subsection (a) of this section for
541 workers' compensation or employers' liability insurance shall be on file
542 with the Insurance Commissioner for a waiting period of thirty days
543 before it becomes effective, which period may be extended by the
544 commissioner for an additional period not to exceed thirty days if the

545 commissioner gives written notice within such waiting period to the
546 insurer or rating organization which made the filing that the
547 commissioner needs such additional time for the consideration of such
548 filing. Upon written application by such insurer or rating organization,
549 the commissioner may authorize a filing which the commissioner has
550 reviewed to become effective before the expiration of the waiting
551 period or any extension thereof. A filing shall be deemed to meet the
552 requirements of sections 38a-663 to 38a-696, inclusive, as amended by
553 this act, unless disapproved by the commissioner within the waiting
554 period or any extension thereof. If, within the waiting period or any
555 extension thereof, the commissioner finds that a filing does not meet
556 the requirements of said sections, the commissioner shall send to the
557 insurer or rating organization which made such filing written notice of
558 disapproval of such filing, specifying therein in what respects the
559 commissioner finds such filing fails to meet the requirements of said
560 sections and stating that such filing shall not become effective. Such
561 finding of the commissioner shall be subject to review as provided in
562 section 38a-19.

563 (2) (A) Each filing as described in subsection (a) of this section for
564 professional liability insurance for physicians and surgeons, hospitals,
565 advanced practice registered nurses or physician assistants shall be
566 subject to prior rate approval in accordance with this section. On and
567 after the effective date of this section, each insurer or rating
568 organization seeking to change its rates for such insurance shall (i) file
569 a request for such change with the Insurance Commissioner, and (ii)
570 send written notice of any request for an increase in rates to insureds
571 who would be subject to the increase. Such request shall be filed and
572 such notice, if applicable, shall be sent at least sixty days prior to the
573 proposed effective date of the change. The notice to insureds of a
574 request for an increase in rates shall indicate that the insured may
575 request a public hearing by submitting a written request to the
576 Insurance Commissioner not later than fifteen days after the date of the
577 notice. Any request for an increase in rates under this subdivision shall
578 be filed after notice is sent to insureds and shall indicate the date such

579 notice was sent.

580 (B) The insurer or rating organization shall demonstrate in the
581 filing, to the satisfaction of the commissioner, that (i) (I) the insurer or
582 rating organization offers a premium reduction or a separate reduced
583 rating classification for insureds who submit proof to the insurer that
584 the insured and its personnel will use an electronic health record
585 system during the premium period to establish and maintain patient
586 records and verify patient treatment, and (II) the premium or rate
587 reduction reflects the reduction in risk related to the use of such
588 system, or (ii) if the insurer or rating organization does not offer such
589 premium or rate reduction, that there is no measurable reduction in
590 risk related to the use of such system.

591 (C) The Insurance Commissioner shall review the filing and, with
592 respect to a request for an increase in rates, shall (i) not approve,
593 modify or deny the request until at least fifteen days after the date of
594 notice as indicated in the filing, and (ii) hold a public hearing, if
595 requested, on such increase prior to approving, modifying or denying
596 the request. The Insurance Commissioner shall approve, modify or
597 deny the filing not later than forty-five days after its receipt. Such
598 finding of the commissioner shall be subject to review as provided in
599 section 38a-19.

600 (c) The form of any insurance policy or contract the rates for which
601 are subject to the provisions of sections 38a-663 to 38a-696, inclusive, as
602 amended by this act, other than fidelity, surety or guaranty bonds, and
603 the form of any endorsement modifying such insurance policy or
604 contract, shall be filed with the Insurance Commissioner prior to its
605 issuance. The commissioner shall adopt regulations, in accordance
606 with the provisions of chapter 54, establishing a procedure for review
607 of such policy or contract. If at any time the commissioner finds that
608 any such policy, contract or endorsement is not in accordance with
609 such provisions or any other provision of law, the commissioner shall
610 issue an order disapproving the issuance of such form and stating the
611 reasons for disapproval. The provisions of section 38a-19 shall apply to

612 any such order issued by the commissioner.

613 Sec. 14. Section 38a-665 of the general statutes is repealed and the
614 following is substituted in lieu thereof (*Effective from passage*):

615 The following standards, methods and criteria shall apply to the
616 making and use of rates pertaining to commercial risk insurance:

617 (a) Rates shall not be excessive or inadequate, as [herein] defined in
618 this section, nor shall [they] rates be unfairly discriminatory. No rate
619 shall be held to be excessive unless (1) such rate is unreasonably high
620 for the insurance provided, or (2) a reasonable degree of competition
621 does not exist in the area with respect to the classification to which
622 such rate is applicable. No rate shall be held inadequate unless (A) it is
623 unreasonably low for the insurance provided, and (B) continued use
624 [of it] would endanger solvency of the insurer, or unless (C) such rate
625 is unreasonably low for the insurance provided and the use of such
626 rate by the insurer [using same has, or, if continued,] has, or if
627 continued will have, the effect of destroying competition or creating a
628 monopoly.

629 (b) (1) Consideration shall be given, to the extent possible, to past
630 and prospective loss experience within and outside this state, to
631 conflagration and catastrophe hazards, to a reasonable margin for
632 underwriting profit and contingencies, to past and prospective
633 expenses both country-wide and those specially applicable to this
634 state, to investment income earned or realized by insurers both from
635 their unearned premium and loss reserve funds, and to all other
636 factors, including judgment factors, deemed relevant within and
637 outside this state and in the case of fire insurance rates, consideration
638 may be given to the experience of the fire insurance business during
639 the most recent five-year period for which such experience is available.
640 Consideration may be given in the making and use of rates to
641 dividends, savings or unabsorbed premium deposits allowed or
642 returned by insurers to their policyholders, members or subscribers.

643 (2) With respect to rates for professional liability insurance for
644 physicians and surgeons, hospitals, advanced practice registered
645 nurses or physician assistants, consideration shall be given in the
646 making and use of such rates to relevant factors that may reduce such
647 rates, including, but not limited to: (A) Amendments to the offer of
648 judgment provisions in section 52-192a, as amended by this act, and
649 section 52-194, as amended by this act, (B) the other provisions of this
650 act, and (C) any reduction in risk from the use of electronic health
651 record systems to establish and maintain patient records and verify
652 patient treatment.

653 (c) The systems of expense provisions included in the rates for use
654 by any insurer or group of insurers may differ from those of other
655 insurers or groups of insurers to reflect the operating methods of any
656 such insurer or group with respect to any kind of insurance, or with
657 respect to any subdivision or combination thereof.

658 (d) Risks may be grouped by classifications for the establishment of
659 rates and minimum premiums, provided no surcharge on any motor
660 vehicle liability or physical damage insurance premium may be
661 assigned for (1) any accident involving only property damage of one
662 thousand dollars or less, [or] (2) the first accident involving only
663 property damage of more than one thousand dollars which would
664 otherwise result in a surcharge to the policy of the insured, within the
665 experience period set forth in the insurer's safe driver classification
666 plan, [or] (3) any violation of section 14-219, unless such violation
667 results in the suspension or revocation of the operator's license under
668 section 14-111b, [or] (4) less than three violations of section 14-218a
669 within any one-year period, or (5) any accident caused by an operator
670 other than the named insured, a relative residing in the named
671 insured's household, or a person who customarily operates the insured
672 vehicle. Classification rates may be modified to produce rates for
673 individual risks in accordance with rating plans which provide for
674 recognition of variations in hazards or expense provisions or both.
675 Such rating plans may include application of the judgment of the

676 insurer and may measure any differences among risks that can be
677 demonstrated to have a probable effect upon losses or expenses.

678 (e) Each rating plan shall establish appropriate eligibility criteria for
679 determining significant risks which are to qualify under the plan,
680 provided all such plans shall include as an eligible significant risk the
681 state of Connecticut or its instrumentalities. Rating plans which
682 comply with the provisions of this subsection shall be deemed to
683 produce rates [which] that are not unfairly discriminatory.

684 (f) Notwithstanding the provisions of subsections (a) to (e),
685 inclusive, of this section, no rate shall include [any] an adjustment
686 designed to recover underwriting or operating losses incurred out-of-
687 state.

688 (g) The commissioner may adopt regulations, in accordance with
689 the provisions of chapter 54, concerning rating plans to [effectuate]
690 implement the provisions of this section.

691 Sec. 15. Section 52-251c of the general statutes is repealed and the
692 following is substituted in lieu thereof (*Effective from passage and*
693 *applicable to causes of action accruing on or after said date*):

694 (a) In any claim or civil action to recover damages resulting from
695 personal injury, wrongful death or damage to property occurring on or
696 after October 1, 1987, the attorney and the claimant may provide by
697 contract, which contract shall comply with all applicable provisions of
698 the rules of professional conduct governing attorneys adopted by the
699 judges of the Superior Court, that the fee for the attorney shall be paid
700 contingent upon, and as a percentage of: (1) Damages awarded and
701 received by the claimant; or (2) settlement amount pursuant to a
702 settlement agreement.

703 (b) In any such contingency fee arrangement such fee shall be the
704 exclusive method for payment of the attorney by the claimant and
705 shall not exceed an amount equal to a percentage of the damages
706 awarded and received by the claimant or of the settlement amount

707 received by the claimant as follows: (1) Thirty-three and one-third per
708 cent of the first three hundred thousand dollars; (2) twenty-five per
709 cent of the next three hundred thousand dollars; (3) twenty per cent of
710 the next three hundred thousand dollars; (4) fifteen per cent of the next
711 three hundred thousand dollars; and (5) ten per cent of any amount
712 which exceeds one million two hundred thousand dollars.

713 (c) (1) Whenever a claimant in a medical malpractice case enters into
714 a contingency fee arrangement with an attorney which provides for a
715 fee that would exceed the percentage limitations set forth in subsection
716 (b) of this section, such arrangement shall not be valid unless the
717 claimant's attorney files an application with the court for approval of
718 such arrangement and the court, after a hearing, grants such
719 application. The claimant's attorney shall attach to such application a
720 copy of such fee arrangement and the proposed unsigned writ,
721 summons and complaint in the case. Such fee arrangement shall
722 provide that the attorney will advance all costs in connection with the
723 investigation and prosecution or settlement of the case and the
724 claimant will not be liable for the reimbursement of the attorney for
725 any such costs if there is no recovery.

726 (2) At the hearing the court shall address the claimant personally to
727 determine if the claimant understands his or her rights under
728 subsection (b) of this section and has knowingly and voluntarily
729 waived such rights. The court shall grant such application if it finds
730 that the claimant has knowingly and voluntarily waived such rights
731 and that the case is so substantially complex, unique or different from
732 other medical malpractice cases as to warrant a deviation from such
733 percentage limitations. The claimant's attorney shall have the burden
734 of showing at the hearing that such deviation is warranted. In no event
735 shall the court grant an application approving a fee arrangement that
736 provides for a fee that exceeds an amount equal to thirty-three and
737 one-third per cent of the damages awarded and received by the
738 claimant or of the settlement amount received by the claimant. If the
739 court denies the application, the court shall advise the claimant of the
740 claimant's right to seek representation by another attorney willing to

741 abide by the percentage limitations set forth in subsection (b) of this
742 section. Only one application may be filed under this subsection with
743 respect to the claimant and the claimant's case.

744 (3) The filing of such application shall toll the applicable statute of
745 limitations until ninety days after the court's decision to grant or deny
746 the application. The decision of the court to grant or deny the
747 application shall not be subject to appeal. The Chief Court
748 Administrator shall assign a judge or judges with experience in
749 personal injury cases to hear and determine applications filed under
750 this subsection. A transcript of the hearing shall be prepared, and such
751 transcript shall be sealed and available for the use of the court only.

752 (d) If the attorney makes disbursements or incurs costs in
753 connection with the investigation and prosecution or settlement of the
754 claim or civil action for which the claimant is liable, in no event shall
755 the claimant be required to pay interest on the amount of such
756 disbursements and costs.

757 [(c) For] (e) (1) Except as provided in subdivision (2) of this
758 subsection, for the purposes of this section, "damages awarded and
759 received" means in a civil action in which final judgment is entered,
760 that amount of the judgment or amended judgment entered by the
761 court that is received by the claimant; [, except that in a civil action
762 brought pursuant to section 38a-368 such amount shall be reduced by
763 any basic reparations benefits paid to the claimant pursuant to section
764 38a-365;] "settlement amount received" means in a claim or civil action
765 in which no final judgment is entered, the amount received by the
766 claimant pursuant to a settlement agreement; [, except that in a claim
767 or civil action brought pursuant to section 38a-368 such amount shall
768 be reduced by any basic reparations benefits paid to the claimant
769 pursuant to section 38a-365;] and "fee" shall not include disbursements
770 or costs incurred in connection with the prosecution or settlement of
771 the claim or civil action, other than ordinary office overhead and
772 expense.

773 (2) For the purposes of this section and with respect to a medical
774 malpractice case in which an application was granted by a court
775 pursuant to subsection (c) of this section, "damages awarded and
776 received" means in a medical malpractice civil action in which final
777 judgment is entered, that amount of the judgment or amended
778 judgment entered by the court that is received by the claimant after
779 deduction for any disbursements made or costs incurred by the
780 attorney in connection with the investigation and prosecution or
781 settlement of the civil action, other than ordinary office overhead and
782 expense, for which the claimant is liable; and "settlement amount
783 received" means in a medical malpractice claim or civil action in which
784 no final judgment is entered, the amount received by the claimant
785 pursuant to a settlement agreement after deduction for any
786 disbursements made or costs incurred by the attorney in connection
787 with the investigation and prosecution or settlement of the claim or
788 civil action, other than ordinary office overhead and expense, for
789 which the claimant is liable.

790 Sec. 16. Section 38a-395 of the general statutes is repealed and the
791 following is substituted in lieu thereof (*Effective January 1, 2005*):

792 [The Insurance Commissioner may require all insurance companies
793 writing medical malpractice insurance in this state to submit, in such
794 manner and at such times as he specifies, such information as he
795 deems necessary to establish a data base on medical malpractice,
796 including information on all incidents of medical malpractice, all
797 settlements, all awards, other information relative to procedures and
798 specialties involved and any other information relating to risk
799 management.]

800 (a) As used in this section:

801 (1) "Claim" means a request for indemnification filed by a medical
802 professional or entity pursuant to a professional liability policy for a
803 loss for which a reserve amount has been established by an insurer;

804 (2) "Closed claim" means a claim that has been settled, or otherwise

805 disposed of, where the insurer has made all indemnity and expense
806 payments on the claim; and

807 (3) "Insurer" means an insurer, as defined in section 38a-1, as
808 amended, that insures a medical professional or entity against
809 professional liability. "Insurer" includes, but is not limited to, a captive
810 insurer or a self-insured person.

811 (b) On and after January 1, 2005, each insurer shall provide to the
812 Insurance Commissioner a closed claim report, on such form as the
813 commissioner prescribes, in accordance with this section. The insurer
814 shall submit the report not later than ten days after the last day of the
815 calendar quarter in which a claim is closed. The report shall only
816 include information about claims settled under the laws of this state.

817 (c) The closed claim report shall include:

818 (1) Details about the insured and insurer, including: (A) The name
819 of the insurer; (B) the professional liability insurance policy limits and
820 whether the policy was an occurrence policy or was issued on a claims-
821 made basis; (C) the name, address, health care provider professional
822 license number and specialty coverage of the insured; and (D) the
823 insured's policy number and a unique claim number.

824 (2) Details about the injury or loss, including: (A) The date of the
825 injury or loss that was the basis of the claim; (B) the date the injury or
826 loss was reported to the insurer; (C) the name of the institution or
827 location at which the injury or loss occurred; (D) the type of injury or
828 loss, including a severity of injury rating that corresponds with the
829 severity of injury scale that the Insurance Commissioner shall establish
830 based on the severity of injury scale developed by the National
831 Association of Insurance Commissioners; and (E) the name, age and
832 gender of any injured person covered by the claim. Any individually
833 identifiable health information, as defined in 45 CFR 160.103, as from
834 time to time amended, submitted pursuant to this subdivision shall be
835 confidential. The reporting of the information is required by law. If
836 necessary to comply with federal privacy laws, including the Health

837 Insurance Portability and Accountability Act of 1996, P.L. 104-191, as
838 from time to time amended, the insured shall arrange with the insurer
839 to release the required information.

840 (3) Details about the claims process, including: (A) Whether a
841 lawsuit was filed, and if so, in which court; (B) the outcome of such
842 lawsuit; (C) the number of other defendants, if any; (D) the stage in the
843 process when the claim was closed; (E) the dates of the trial; (F) the
844 date of the judgment or settlement, if any; (G) whether an appeal was
845 filed, and if so, the date filed; (H) the resolution of the appeal and the
846 date such appeal was decided; (I) the date the claim was closed; (J) the
847 initial indemnity and expense reserve for the claim; and (K) the final
848 indemnity and expense reserve for the claim.

849 (4) Details about the amount paid on the claim, including: (A) The
850 total amount of the initial judgment rendered by a jury or awarded by
851 the court; (B) the total amount of the settlement if there was no
852 judgment rendered or awarded; (C) the total amount of the settlement
853 if the claim was settled after judgment was rendered or awarded; (D)
854 the amount of economic damages, as defined in section 52-572h, or the
855 insurer's estimate of the amount in the event of a settlement; (E) the
856 amount of noneconomic damages, as defined in section 52-572h, or the
857 insurer's estimate of the amount in the event of a settlement; (F) the
858 amount of any interest awarded due to failure to accept an offer of
859 judgment; (G) the amount of any remittitur or additur; (H) the amount
860 of final judgment after remittitur or additur; (I) the amount paid by the
861 insurer; (J) the amount paid by the defendant due to a deductible or a
862 judgment or settlement in excess of policy limits; (K) the amount paid
863 by other insurers; (L) the amount paid by other defendants; (M)
864 whether a structured settlement was used; (N) the expense assigned to
865 and recorded with the claim, including, but not limited to, defense and
866 investigation costs, but not including the actual claim payment; and
867 (O) any other information the commissioner determines to be
868 necessary to regulate the professional liability insurance industry with
869 respect to medical professionals and entities, ensure the industry's
870 solvency and ensure that such liability insurance is available and

871 affordable.

872 (d) (1) The commissioner shall establish an electronic database
873 composed of closed claim reports filed pursuant to this section.

874 (2) The commissioner shall compile the data included in individual
875 closed claim reports into an aggregated summary format and shall
876 prepare a written annual report of the summary data. The report shall
877 provide an analysis of closed claim information including a minimum
878 of five years of comparative data, when available, trends in frequency
879 and severity of claims, itemization of damages, timeliness of the claims
880 process, and any other descriptive or analytical information that would
881 assist in interpreting the trends in closed claims.

882 (3) The annual report shall include a summary of rate filings for
883 professional liability insurance for medical professionals and entities
884 which have been approved by the department for the prior calendar
885 year, including an analysis of the trend of direct losses, incurred losses,
886 earned premiums and investment income as compared to prior years.
887 The report shall include base premiums charged by medical
888 malpractice insurers for each specialty and the number of providers
889 insured by specialty for each insurer.

890 (4) Not later than March 15, 2006, and annually thereafter, the
891 commissioner shall submit the annual report to the joint standing
892 committee of the General Assembly having cognizance of matters
893 relating to insurance in accordance with section 11-4a. The
894 commissioner shall also (A) make the report available to the public, (B)
895 post the report on its Internet site, and (C) provide public access to the
896 contents of the electronic database after the commissioner establishes
897 that the names and other individually identifiable information about
898 the claimant and practitioner have been removed.

899 (e) The Insurance Commissioner shall provide the Commissioner of
900 Public Health with electronic access to all information received
901 pursuant to this section. The Commissioner of Public Health shall
902 maintain the confidentiality of such information in the same manner

903 and to the same extent as required for the Insurance Commissioner.

904 Sec. 17. (NEW) (*Effective from passage*) (a) The Commissioner of
905 Public Health shall develop and implement a process that will ensure a
906 continuing and coordinated focus on patient safety programs within
907 the Department of Public Health. Such process shall encompass
908 activities undertaken by the department to (1) coordinate state
909 initiatives on patient safety, (2) facilitate ongoing collaborations
910 between the public and private sectors, (3) promote patient safety
911 through education of health care providers and patients, (4) assure
912 coordination in collecting, analyzing and responding to adverse events
913 reports submitted to the department pursuant to section 19a-127n of
914 the general statutes, (5) coordinate state and federal patient safety
915 programs, (6) participate in the federal Patient Safety Improvement
916 Corps to identify the causes of medical errors, and (7) promote the
917 recommendations of the Quality of Care Advisory Committee.

918 (b) On or before January 1, 2005, and annually thereafter, the
919 Commissioner of Public Health shall submit a report, in accordance
920 with the provisions of section 11-4a of the general statutes, to the
921 Governor and the chairpersons of the joint standing committee of the
922 General Assembly having cognizance of matters relating to public
923 health, providing a description of the process developed pursuant to
924 subsection (a) of this section, an analysis of its operation and impact
925 with respect to the activities enumerated in subsection (a) of this
926 section, a description of the activities undertaken by the department's
927 patient safety programs, and recommendations for future action.

928 Sec. 18. (NEW) (*Effective from passage*) Whenever in a civil action to
929 recover damages resulting from personal injury or wrongful death,
930 whether in tort or in contract, in which it is alleged that such injury or
931 death resulted from the negligence of a health care provider, the jury
932 renders a verdict specifying noneconomic damages, as defined in
933 section 52-572h of the general statutes, in an amount exceeding one
934 million dollars, the court shall review the evidence presented to the
935 jury to determine if the amount of noneconomic damages specified in

936 the verdict is excessive as a matter of law in that it so shocks the sense
937 of justice as to compel the conclusion that the jury was influenced by
938 partiality, prejudice, mistake or corruption. If the court so concludes, it
939 shall order a remittitur and, upon failure of the party so ordered to
940 remit the amount ordered by the court, it shall set aside the verdict and
941 order a new trial.

942 Sec. 19. (NEW) (*Effective July 1, 2004, and applicable to taxable years*
943 *commencing on or after January 1, 2004*) (a) Any resident of this state, as
944 defined in subdivision (1) of subsection (a) of section 12-701 of the
945 general statutes, as amended, who is a physician and who is subject to
946 the tax imposed under chapter 229 of the general statutes for any
947 taxable year shall be entitled to a credit in determining the amount of
948 tax liability under said chapter, for a portion, as permitted by this
949 section, of the amount of medical malpractice insurance premiums first
950 becoming due and actually paid during such taxable year by such
951 person in accordance with this section.

952 (b) The credit allowed under this section shall be equal to one
953 hundred per cent of the amount by which the medical malpractice
954 insurance premiums first becoming due and actually paid during such
955 taxable year by such person exceed twenty-five per cent of the person's
956 Connecticut taxable income, provided such credit shall not exceed an
957 amount equal to fifteen per cent of such premiums.

958 (c) The credit may only be used to reduce such qualifying taxpayer's
959 tax liability for the year for which such credit is applicable and shall
960 not be used to reduce such tax liability to less than zero.

961 (d) The amount of tax due pursuant to sections 12-705 and 12-722 of
962 the general statutes shall be calculated without regard to this credit.

963 (e) Any physician who has had, at any time, a judgment entered
964 against him or her as a defendant in a civil action to recover damages
965 for personal injury or wrongful death resulting from the acts or
966 omissions of such physician in the medical diagnosis, care or treatment
967 of a person shall not be entitled to a credit under this section.

968 Sec. 20. Subsection (c) of section 46 of public act 03-1 of the June 30
969 special session is repealed and the following is substituted in lieu
970 thereof (*Effective from passage*):

971 (c) Notwithstanding any provision of the general statutes, for the
972 fiscal year ending June 30, 2004, and the fiscal year ending June 30,
973 2005, the sum of \$2,000,000 shall be transferred from the resources of
974 the Biomedical Research Trust Fund and credited to the resources of
975 the General Fund, except that for the fiscal year ending June 30, 2005,
976 any necessary portion of said sum shall be allocated to offset the
977 revenue loss resulting from the tax credit established in section 19 of
978 this act, as certified by the Commissioner of Revenue Services.

979 Sec. 21. Section 38a-25 of the general statutes is repealed and the
980 following is substituted in lieu thereof (*Effective from passage*):

981 (a) The Insurance Commissioner is the agent for receipt of service of
982 legal process on the following:

983 (1) Foreign and alien insurance companies authorized to do
984 business in this state in any proceeding arising from or related to any
985 transaction having a connection with this state.

986 (2) Fraternal benefit societies authorized to do business in this state.

987 (3) Insurance-support organizations as defined in section 38a-976,
988 transacting business outside this state which affects a resident of this
989 state.

990 (4) Risk retention groups, as defined in section 38a-250. [designating
991 the Insurance Commissioner as agent for receipt of service of process
992 pursuant to section 38a-252.]

993 (5) Purchasing groups designating the Insurance Commissioner as
994 agent for receipt of service of process pursuant to section 38a-261.

995 (6) Eligible surplus lines insurers authorized by the commissioner to
996 accept surplus lines insurance.

997 (7) Except as provided by section 38a-273, unauthorized insurers or
998 other persons assisting unauthorized insurers who directly or
999 indirectly do any of the acts of insurance business as set forth in
1000 subsection (a) of section 38a-271.

1001 (8) The Connecticut Insurance Guaranty Association and the
1002 Connecticut Life and Health Insurance Guaranty Association.

1003 (9) Insurance companies designating the Insurance Commissioner
1004 as agent for receipt of service of process pursuant to subsection (g) of
1005 section 38a-85.

1006 (10) Nonresident insurance producers and nonresident surplus lines
1007 brokers licensed by the Insurance Commissioner.

1008 (11) Viatical settlement providers, viatical settlement brokers, and
1009 viatical settlement investment agents licensed by the commissioner.

1010 (12) Nonresident reinsurance intermediaries designating the
1011 commissioner as agent for receipt of service of process pursuant to
1012 section 38a-760b.

1013 (13) Workers' compensation self-insurance groups, as defined in
1014 section 38a-1001.

1015 (14) Persons alleged to have violated any provision of section 38a-
1016 130.

1017 (15) Captive insurers, as defined in section 38a-91.

1018 (b) Each foreign and alien insurer by applying for and receiving a
1019 license to do insurance business in this state, each fraternal benefit
1020 society by applying for and receiving a certificate to solicit members
1021 and do business, each surplus lines insurer declared to be an eligible
1022 surplus lines insurer by the commissioner, each insurance-support
1023 organization transacting business outside this state which affects a
1024 resident of this state, and each unauthorized insurer by doing an act of
1025 insurance business prohibited by section 38a-272, is considered to have

1026 irrevocably appointed the Insurance Commissioner as [his] agent for
1027 receipt of service of process in accordance with subsection (a) of this
1028 section. Such appointment shall continue in force so long as any
1029 certificate of membership, policy or liability remains outstanding in
1030 this state.

1031 (c) The commissioner is also agent for the executors, administrators
1032 or personal representatives, receivers, trustees or other successors in
1033 interest of the persons specified under subsection (a) of this section.

1034 (d) Any legal process that is served on the commissioner pursuant
1035 to this section shall be of the same legal force and validity as if served
1036 on the principal.

1037 (e) The right to effect service of process as provided under this
1038 section does not limit the right to serve legal process in any other
1039 manner provided by law.

1040 Sec. 22. (NEW) (*Effective July 1, 2004*) Each captive insurer, as
1041 defined in section 38a-91 of the general statutes, that offers, renews or
1042 continues insurance in this state shall provide the information
1043 described in subsection (a) of section 38a-253 of the general statutes to
1044 the Insurance Commissioner in the same manner required for risk
1045 retention groups. If a captive insurer does not maintain information in
1046 the form prescribed in section 38a-253 of the general statutes, the
1047 captive insurer may submit the information to the Insurance
1048 Commissioner on such form as the commissioner prescribes. The
1049 provisions of this section shall not apply to a captive insurer that is
1050 otherwise required by law to submit such information to the
1051 commissioner.

1052 Sec. 23. (*Effective from passage*) Sections 38a-32 to 38a-36, inclusive, of
1053 the general statutes are repealed.

This act shall take effect as follows:	
Section 1	<i>from passage</i>

Sec. 2	<i>from passage and applicable to actions filed on or after said date</i>
Sec. 3	<i>from passage</i>
Sec. 4	<i>from passage</i>
Sec. 5	<i>from passage</i>
Sec. 6	<i>from passage</i>
Sec. 7	<i>from passage</i>
Sec. 8	<i>from passage</i>
Sec. 9	<i>from passage</i>
Sec. 10	<i>from passage</i>
Sec. 11	<i>from passage</i>
Sec. 12	<i>from passage</i>
Sec. 13	<i>from passage</i>
Sec. 14	<i>from passage</i>
Sec. 15	<i>from passage and applicable to causes of action accruing on or after said date</i>
Sec. 16	<i>January 1, 2005</i>
Sec. 17	<i>from passage</i>
Sec. 18	<i>from passage</i>
Sec. 19	<i>July 1, 2004, and applicable to taxable years commencing on or after January 1, 2004</i>
Sec. 20	<i>from passage</i>
Sec. 21	<i>from passage</i>
Sec. 22	<i>July 1, 2004</i>
Sec. 23	<i>from passage</i>

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 04\$	FY 05\$	FY 06\$
Insurance Dept.	IF - Cost	0	210,878	224,215
Public Health, Dept.	GF - Cost	50,500	776,880	687,880
Comptroller Misc. Accounts (Fringe Benefits)	GF - Cost	10,100	131,000	296,290
Revenue Serv., Dept.	GF - Cost	0	250,000	100,000
Revenue Serv., Dept.	GF - Revenue Loss		2.5 million - 5 million	2.5 million - 5 million

Note: IF=Insurance Fund; GF=General Fund

Municipal Impact: None

Explanation

Section 1 provides for mediation between parties to a civil action involving medical malpractice by requiring them either to engage in mediation by a judge of the superior court or participate in an alternative dispute resolution program paid for by the parties. According to the amendment, such mediation or alternative dispute resolution shall not stay or delay the prosecution of the case, and shall be for the specified purposes of: (1) reviewing certificates of good faith; (2) attempting to achieve prompt settlement or resolution of cases; and (3) expediting litigation of cases. To the extent that this new process speeds disposition of medical malpractice cases, a workload reduction to the Civil Division of the Superior Court would result.

Section 2 modifies the certificate of good faith requirement in medical malpractice cases. The additional requirements that the amendment places on the submittal of certificates of good faith could reduce the number of medical malpractice cases brought before the

Superior Court, thereby decreasing the workload of the Civil Division. Any such change would be small relative to the overall caseload since medical malpractice cases comprise less than one per cent of total civil cases added each year. Consequently, there is no related fiscal impact.

Implementation of Sections 3-5 and 10 will result in a significant cost to the Department of Public Health (DPH). The predominant reason for this is a requirement that the agency review and investigate when warranted all civil actions regarding a medical malpractice claim filed against a licensed physician, chiropractor, dentist or psychologist. Under current law, the agency reviews about 500 complaints and malpractice payment notices annually. Of these, about fifty percent (or 250) progress to an investigation. Under the bill, an additional 380 - 400 filed civil actions would require agency review each year, prompting an additional 190 - 200 investigations. The agency's Practitioner Investigations Unit currently has nine investigators.

The department's workload would also be increased to the extent that: (a) filed claims involve cases in which multiple medical practitioners are named, and (b) the scope of reviews/investigations is broadened following adoption of regulations.

Additional work would be associated with: (a) developing regulations, (b) notifying parties who have filed a petition questioning a physician's ability to practice, or the person's legal representative, when the department makes a finding of no probable cause, and (c) developing systems for public access to information received about medical malpractice claims, awards and settlements and reporting on the same to the Public Health and Insurance Committees by October 1, 2004.

The DPH will incur FY 05 costs of \$613,340 to comply with Sections 3-5 and 10. This reflects the full-year salaries of: one Physician (at \$142,000 annually), one Supervising Nurse Consultant (at \$77,400 annually), two Health Program Associates (at \$55,280 annually), two Nurse Consultants (at \$66,640 annually), one Administrative Hearings

Officer (at an annual salary of \$70,000), one Office Assistant (at an annual salary of \$34,870), and one half-time Systems Developer (at \$31,230 annually). Also included are one-time equipment costs of \$8,000 and other expenses of \$5,000. In FY 06 this cost will decrease to \$604,340 as equipment costs will not recur. DPH costs will be supplemented by fringe benefit¹ costs of \$121,250 in FY 05 and \$274,620 in FY 06. A potential minimal revenue gain would be expected should the enhanced investigation process lead to the collection of additional financial penalties from health care professionals. Since the bill is effective from passage, FY 04 costs of approximately \$50,500 (DPH) and \$10,100 (fringe benefits) would ensue given June 1, 2004 implementation. No funding has been included within sHB 5033 (the Revised FY 05 Appropriations Act, as favorably reported by the Appropriations Committee) for these purposes.

Section 5 requires the Connecticut Medical Examining Board (CMEB), with the assistance of the DPH, to adopt regulations by July 1, 2004, to establish guidelines for use in its disciplinary process. The CMEB and medical hearing panels are comprised of volunteers who are not compensated for their time. Therefore, no direct state cost will result from an increased workload of their members.

Section 6 requires the DPH to include additional information related to medical malpractice investigations in its annual report to the General Assembly. The department will incur FY 05 costs of \$92,940 to support the salary of one half-time Office Assistant (at an annual salary of \$17,440) needed to enter data not presently collected and/or entered into the agency's database, one-time associated equipment

¹ The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The total fringe benefit reimbursement rate as a percentage of payroll is 45.82%, effective July 1, 2003. However, first year fringe benefit costs for new positions do not include pension costs - lowering the rate to 20.23% in FY 05. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System.

costs of \$3,000, and costs of one-time data processing services (approximately \$72,500) needed to revise the agency's computer database and develop reporting tools. In FY 06 this cost will fall to \$17,440, as the consultant services will no longer be required. DPH costs will be supplemented by fringe benefit costs of \$3,530 in FY 05 and \$7,990 in FY 06.

Section 7 requires the DPH to establish protocols for use by each hospital or outpatient surgical facility for screening patients prior to any surgery and report on the same by October 1, 2004. It is anticipated that the agency can do so without requiring additional resources.

Sections 8 and 9 makes changes to the offer of judgment provisions in current law. These changes are not expected to substantially alter the period of time it takes to dispose of civil cases on a system wide basis such that there would be a fiscal impact to the Judicial Department.

Section 11 requires each physician, podiatrist, chiropractor and naturopathic physician to report the name of the insurance company providing his or her professional liability insurance, the policy number, his or her area of specialization, whether he or she is actively involved in patient care, and any disciplinary action or malpractice payment made his or her behalf in another state or jurisdiction. It also allows DPH to compare this information to that contained in the National Practitioner Data Base. **Section 12** requires the DPH to report, by January 1, 2005, and annually thereafter, on the number of physicians by specialty who are actively providing patient care.

The DPH will incur FY 05 costs of \$70,600 to support the salaries of one Office Assistant (at an annual salary of \$34,870), and one half-time Systems Developer (at an annual salary of \$31,230) needed to revise the agency's existing licensure database, enter information, follow-up with physicians who fail to supply the required data, and compile the annual report. Also included in this sum are one-time costs for

equipment (\$3,000) and reprinting the physician renewal card (\$1,500). In FY 06 this cost will fall to \$66,100 as one-time equipment and printing costs will not recur. DPH costs will be supplemented by fringe benefit costs of \$6,320 in FY 05 and \$14,310 in FY 06. It is anticipated that DPH will conduct few National Practitioner Data Bank checks, since each query costs \$4.25 and no funding has been appropriated to the department for this purpose within sHB 5033.

Section 13 requires medical malpractice insurance companies to file a request for rate approval with the Insurance Commissioner 60 days prior to the effective date. In addition, it requires the department to approve or deny a filing within 45 days of the receipt. With current staff, the department would be unable to approve or deny rates within 45 days; for that reason an additional one-half actuary (full-time annual salary of \$110,000) is needed to assure the timeliness of the prior rate approval. The total annual cost in FY 05 will be \$66,127, which includes fringe benefits of \$11,127. The annual cost for FY 06 and subsequent years will be \$80,201, which includes fringe benefit costs of \$25,201.

Section 14 requires the Department of Insurance (DOI) to consider the impact of the amendment's provisions when making rates for commercial risk insurance. This has no fiscal impact on DOI.

Section 15 requires the court to grant any waiver of attorneys' contingency fees in medical malpractice cases. The court could accommodate such reviews within budgeted resources. Consequently, there is no related fiscal impact.

Section 16 requires the Insurance Commissioner to establish an electronic database composed of closed claim reports. It also requires the commissioner to provide an annual report consisting of trend analysis of closed claim information. Due to the need to collect, input, and process additional information the department would incur costs of \$144,751 in FY 05. These costs would consist of \$42,500 in other expenses, \$69,188 in salary and fringe benefits for an examiner (annual

salary \$57,546), and \$33,063 in salary and fringe benefits for one-quarter of an actuary. In FY 06 the department would incur \$20,000 in other expenses, \$40,101 in salary and fringe benefits for a one-quarter actuary and \$83,914 in salary and fringe benefits for an examiner. Therefore, the department would incur costs of \$144,751 in FY 05 and \$144,014 in FY 06 due to closed claim reporting.

Section 17 requires the Department of Public Health to develop and implement a process that will ensure a continuing and coordinated focus on patient safety programs within the department. It further requires the department to submit a report annually, commencing on or before January 1, 2005, to the Public Health Committee. It is anticipated that the agency can accommodate these requirements without requiring additional resources.

Section 18 requires the court to review any jury verdict in a medical malpractice case having an award for non-economic damages that exceeds \$1 million in order to determine if the non-economic damages award is excessive. The court could accommodate such reviews through a workload increase, which would not require additional appropriations.

Section 19 establishes a tax credit for medical malpractice insurance premiums. The annual revenue loss to the personal income tax is estimated to be \$2.5 million - \$5 million beginning in FY 05. The Department of Revenue Services would incur a one-time cost of \$250,000 in FY 05 to make programming and tax form changes and a cost of \$100,000 in FY 06 and subsequent years for on-going administration and audit.

Section 20 allocates existing General Fund revenues of up to \$2 million to offset the revenue loss from the tax credit in **Section 19** of the amendment. This would result in no fiscal impact, as this funding has already been incorporated into the General Fund revenue schedule for FY 05.

Sections 21 and 22 require captive insurers to submit certain

information to the Department of Insurance. This has no fiscal impact.

Section 23 eliminates the voluntary medical malpractice-screening panel existing under current law. There is no resulting fiscal impact since this panel has not been used.

House "A" strikes the language of the bill and eliminates the associated fiscal impact. It results in the fiscal impact stated above.

House "D" alters the rate approval process and factors that should be taken into consideration upon making rates. It has no fiscal impact.

OLR BILL ANALYSIS

sHB 5669 (as amended by House "A" and "D")*

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM**SUMMARY:**

This bill makes numerous changes to the laws dealing with civil litigation; insurance regulation and oversight; and the regulation, oversight, and disciplining of doctors. It also gives certain physicians a tax credit for a portion of their medical malpractice insurance premiums.

Civil Litigation Reform

The bill:

1. establishes a mandatory mediation program for medical malpractice lawsuits filed after the bill becomes law, which must be used unless the parties have agreed to use an alternative dispute resolution program (§1),
2. requires, as a condition of filing a medical malpractice lawsuit or an apportionment complaint in such a lawsuit, that a signed opinion of a similar health care provider be prepared to show the existence of a good faith belief that there has been negligence and a copy be attached to the lawsuit complaint (§2);
3. changes the interest rate the court may award the plaintiff with respect to an offer of judgment for medical malpractice causes of action that accrue after the bill's effective date by reducing (a) from 12% to 8% the interest the court must add to the portion of the award up to twice the amount stated in the offer of judgment, and (b) from 12% to 4% the interest the court must add to the portion of the award that exceeds twice the amount stated in the offer of judgment (§8);
4. gives the plaintiff 60, instead of 10, days after being notified by the defendant of his offer of judgment to accept it and gives courts the authority to give plaintiffs and defendants up to an additional 120 days to accept an offer of judgment (§§ 8 & 9);
5. allows the attorney fee schedule for contingency fees in medical

malpractice cases to be waived only upon an application to and approval by a judge, places the burden on the claimant's attorney to show that deviation from the schedule is warranted due to the nature of the case, requires that the fee be calculated after any disbursements and costs for which the plaintiff is liable have been deducted, and prohibits fees greater than one-third of the damages awarded (§ 15);

6. requires the court, in any medical malpractice case in which the jury awards more than \$1,000,000 in noneconomic damages, to review the evidence to determine if the amount of noneconomic damages is excessive as a matter of law (§18), and
7. eliminates the Medical Malpractice Screening Panel (§23).

Insurance Regulation and Oversight

The bill:

1. requires prior rate approval by the Insurance Department for medical malpractice insurance rate changes for physicians and surgeons, hospitals, advanced practice registered nurses, or physician assistants and, in such process, requires the insurers to either offer a discount for those who use an electronic records system or demonstrate that its use does not reduce the risk (§13);
2. requires that consideration be given to relevant factors that may reduce rates when establishing malpractice rates for physicians and surgeons, hospitals, advanced practice registered nurses, or physician assistants, including (a) amendments the bill makes to the offer of judgment law, (b) other provisions of the bill, and (c) any reduction in risk from using electronic health record systems to establish and maintain patient records and verify patient treatment (§14);
3. beginning June 1, 2005, (a) requires entities that insure people or entities against medical malpractice lawsuits to provide the insurance commissioner with a closed claim report on each malpractice claim that the insurer closes; (b) the report to include details about the insured and insurer, the injury or loss, the claims process, and the amount paid but exclude any individually identifiable information defined in federal regulation as confidential; and (c) requires that if necessary to comply with federal privacy laws, the insured must arrange with the insurer to release the required information (§16);
4. requires the commissioner to compile and analyze the data and

- annually submit a report on this to the Insurance and Real Estate Committee and the public (§16); and
5. requires each captive insurer that offers, renews, or continues insurance in Connecticut to provide certain information to the insurance commissioner in the same manner required for risk retention groups (§§21 and 22).

Regulation, Oversight, and Discipline of Medical Providers

The bill:

1. requires the plaintiff or his attorney to mail a copy of a medical malpractice complaint to the Department of Public Health (DPH) and the Insurance Department when he files a lawsuit against a licensed physician and certain other licensed health care providers, and requires DPH to determine if there is a basis for further investigations or disciplinary action (§3);
2. requires anyone who pays a medical malpractice award or settlement to provide copies of the award or settlement and complaint and answer, if any, to the Insurance Department instead of just DPH (§3);
3. requires those paying medical malpractice awards or settlements for licensed physicians and certain other health care providers to provide additional information to DPH, including a breakdown by economic and noneconomic damages (§4);
4. makes liability releases invalid until the attorney representing the paying party files an affidavit with the court that he has provided DPH and the insurance commissioner with the required information (§3)
5. requires DPH and the insurance commissioner to develop systems to collect, store, use, interpret, report, and provide public access to such information (§3);
6. requires DPH to adopt guidelines to determine the basis for further investigation or disciplinary action regarding physicians who paid damages or were sued for malpractice (§3);
7. requires DPH to adopt regulations establishing guidelines for screening complaints, prioritizing investigations, and determining when an investigation should be broadened (§4);
8. requires the Medical Examining Board, with DPH's assistance, to adopt guidelines for its disciplinary process and requires the DPH commissioner to conduct a hearing on charges against a doctor if a hearing panel the board appoints has not done so within 60 days

- after the board reports charges to it (§5);
9. requires that DPH's annual report to the governor and Public Health Committee include additional information such as the number of complaints filed against doctors, and the number of notices of malpractice lawsuits filed that were not investigated and the reasons why (§6);
 10. requires DPH to develop protocols for accurate identification procedures that hospitals and outpatient surgical facilities must use before surgery (§7)
 11. requires DPH to notify the physician and person who filed a petition or his legal representative when it makes a finding of no probable cause and include the reason for such finding (§10);
 12. requires doctors annually to provide certain information to DPH, including their malpractice insurer, policy number, area of specialization, and disciplinary actions and malpractice payments made in other jurisdictions and allows doctors to fulfill this obligation by including such information in their physician profile (§11);
 13. requires DPH to report annually the number of doctors, by specialty, actively providing patient care (§12); and
 14. requires the DPH commissioner to develop and implement a process that will ensure a continuing and coordinated focus on patient safety programs within DPH (§17).

Tax Credit

The bill gives any state resident who is a physician and who is subject to the state income tax for any taxable year the right to a credit in determining the amount of income tax liability for a portion of the amount of medical malpractice insurance premiums first becoming due and actually paid during the taxable year. The credit is applicable to tax years beginning January 1, 2004. The bill funds the credit for the fiscal year ending June 30, 2005 by transferring from the \$2,000,000 being transferred to the General Fund from the Biomedical Research Trust Fund (§§19 &20).

EFFECTIVE DATE: The bill takes effect upon passage, except the provision dealing with the duty of captive insurers to provide certain information to the insurance commissioner takes effect July 1, 2004; the provision providing tax credits takes effect July 1, 2004 and applies taxable years beginning January 1, 2004; and the provision requiring the data on closed cases takes effect January 1, 2005.

*House Amendment "A" replaces the file and in doing so makes numerous changes to the file. Specifically, it

1. eliminates the requirement that the DPH commissioner designate a patient safety ombudsman within DPH to improve patient safety and reduce medical errors and instead requires the DPH commissioner to develop and implement a process that will ensure a continuing and coordinated focus on patient safety programs within DPH;
2. eliminates the provision that allows licensed physicians to deduct from their Connecticut adjusted gross income for state income tax purposes any amount they paid for premiums on a medical malpractice insurance policy and instead gives them the right to a credit in determining the amount of income tax liability for a portion of the amount of medical malpractice insurance premiums first becoming due and actually paid during the taxable year.
3. eliminates the requirement for a loan forgiveness program the state provides to people to complete medical training in obstetrics or neurosurgery at a medical school in Connecticut accredited by the Liaison Committee on Medical Education or the American Osteopathic Association and eliminates the requirement that money for the program and to offset the tax losses caused by the deductions come from the Tobacco Settlement Fund;
4. eliminates the requirement that the Connecticut Health and Educational Facilities Authority establish the Connecticut Physician Insurance Program as a pilot program to finance and provide grants of up to \$ 750,000 in the aggregate to nonprofit hospitals to provide medical malpractice indemnity or insurance to physicians and surgeons who enjoy privileges at the hospitals;
5. eliminates the prohibition against a captive insurer insuring a health care provider or entity in Connecticut against liability for medical malpractice unless it has obtained a certificate of authority from the insurance commissioner;
6. requires that upon filing a medical malpractice case against podiatrists and optometrists, the plaintiff or his attorney must mail a copy of the complaint to the DPH and the Insurance Department as they must now do for certain other medical professionals;
7. specifies that the receipt or review of a copy of a complaint may not be considered an investigation of the individual licensee by the DPH or any examining board;
8. requires the DPH commissioner, by July 1, 2004, to adopt

- regulations that establish (a) guidelines to provide a basis for prioritizing the order in which complaints will be investigated, (b) a system for conducting investigations to ensure prompt action when it appears necessary, and (c) guidelines to protect and ensure the confidentiality of patient and provider identifiable information when an investigation is broadened beyond the initial complaint;
9. requires that by July 1, 2004, the Connecticut Medical Examining Board, with DPH's assistance, adopt regulations that establish guidelines for use in the disciplinary process that include a range of penalties for each type of violation, instead of minimum and maximum penalties for each type of violation;
 10. requires that one member of the DPH disciplinary hearing panel be a similar health care provider, as defined by law, to the person who is the subject of the complaint, and two must be public members;
 11. eliminates the requirement that any finding of no probable cause by DPH after investigation be reviewed by a hearing panel the board appoints and authorizes the panel to ask DPH to provide more information or reconsider its findings;
 12. eliminates the requirement that hospitals and outpatients surgical facilities establish certain presurgery identification protocols and instead requires DPH to develop such protocols that hospitals and outpatient surgical facilities must use;
 13. eliminates the provision that reduces the amount of interest that a defendant must pay under the offer of judgment law from a flat rate of 12% to 6% on that portion of the award that exceeds twice the amount specified in the offer of judgment, and instead changes the interest rate the court may award with respect to an offer of judgment for medical malpractice causes of action that accrue after the bill's effective date by reducing (a) from 12% to 8% the interest the court must add to the portion of the award up to twice the amount stated in the offer of judgment and (b) from 12% to 4% the interest the court must add to the portion of the award that exceeds twice the amount stated in the offer of judgment;
 14. gives the plaintiff 60 instead of 10 days after being notified by the defendant of his offer to accept it and allows courts to give plaintiffs up to an additional 120 days to accept the defendant's offer of judgment;
 15. eliminates the provision in the file that specifies that the investigation remain confidential only if the medical panel the board appointed allows the finding of no probable cause to stand;
 16. requires DPH to notify the physician when it makes a finding of no probable cause;

17. allows doctors to fulfill their obligation to annually provide information to DPH about their insurance, specialization, and disciplinary actions and malpractice payments in other states by including it in their physician profile;
18. eliminates the requirement that the insurance commissioner hold a public hearing on medical malpractice rate increases and instead requires a hearing if an insured requests one;
19. eliminates the requirement that insurance companies offer discounts of at least 10% to health care providers that maintain an electronic health record system, and instead requires them to offer a discount or convince the commissioner in the prior rate approval process that use of the system does not reduce risk;
20. eliminates the requirement that the Connecticut Health and Educational Facilities Authority (CHEFA) establish a grant program for hospitals to upgrade their health record system;
21. eliminates the requirement that CHEFA establish a pilot program to finance and provide grants of up to \$ 750,000 in the aggregate to nonprofit hospitals to provide medical malpractice indemnity or insurance to physicians and surgeons who enjoy privileges at the hospitals;
22. requires that consideration be given to relevant factors that may reduce rates when establishing malpractice rates for physicians and surgeons, hospitals, or advanced practice registered nurses,;
23. requires that (a) at the hearing to determine whether the plaintiff can waive the statutory attorney fee schedule, the court must address the claimant personally to determine if he understands his or her rights and has knowingly and voluntarily waived them and (b) as a condition of granting the waiver, the court find that the claimant has knowingly and voluntarily waived such rights;
24. (a) eliminates the requirement that limits the fee to one-third of the amount of the award or settlement if the waiver is granted; (b) requires that a hearing transcript be prepared and be available for the court's use only; and (c) requires that the fee be calculated after any disbursements and costs for which the plaintiff is liable have been deducted in medical malpractice cases instead of in all cases; and
25. with regard to the closed claim reporting requirements, specifies that any individually identifiable information as defined in 45 CFR 160.103, is confidential. It also specifies that reporting this information is required by law. It requires that if necessary to comply with federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as

amended, the insured must arrange with the insurer to release the required information.

*House Amendment "D" requires prior rate approval by the Insurance Department for medical malpractice insurance rate changes for physician assistants and in such process requires the insurers to either offer a discount for those who use an electronic records system or demonstrate that the use of such a system does not reduce the risk and requires that consideration be given to relevant factors that may reduce rates when establishing malpractice rates for physician assistants including: (a) amendments to the offer of judgment law the bill makes, (b) other provisions of the bill, and (c) any reduction in risk from the use of electronic health record systems to establish and maintain patient records and verify patient treatment (§14);

MANDATORY MEDIATION (§ 1)

The bill establishes a mandatory mediation program for all medical malpractice lawsuits filed after the bill becomes law to:

1. review the good faith certificate filed to determine whether there are grounds for a good faith belief that the defendant was negligent in the claimant's care or treatment,
2. attempt to achieve a prompt settlement or resolution of the case, and
3. expedite the litigation of the case.

The bill requires that medical malpractice cases be referred to mandatory mediation unless the parties have agreed to refer the case to an alternative dispute resolution program.

The bill requires the court clerk to refer the case to a Superior Court judge for mediation when the defendant files his answer. The mediation must occur as soon as is practicable but no later than 30 days after the answer is filed. The bill specifies that mediation does not stay or delay the lawsuit, or delay, discovery.

At the mediation, the court must review the certificate of good faith to determine if there are grounds for a good faith belief that the defendant was negligent in the claimant's care or treatment. If the court determines that the certificate is inadequate to permit such a determination, it may order the party submitting it to file, within 30

days, a supplemental certificate stating the grounds for the opinion that there has been negligence in the claimant's care or treatment.

If the court determines that the certificate or any supplemental certificate is inadequate to support a determination that there are grounds for a good faith belief that there has been negligence, it must order the party asserting the claim to post a \$ 5,000 cash or surety bond as a condition of continuing the case. The bond must be used to pay the other party's taxable costs if the case is not successfully prosecuted.

The bill requires all parties to the case, together with a representative of each insurer that may be liable, to attend the mediation in person, unless attendance by means of telephone is permitted upon written agreement of all parties or written order of the court.

If the mediation does not settle or conclude the case, the court must enter whatever orders are necessary to narrow the issues, expedite discovery, and help the parties prepare the case for trial.

GOOD FAITH CERTIFICATE (§ 2)

Current law prohibits filing malpractice lawsuits unless the attorney or claimant has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that the claimant received negligent care or treatment. The complaint or initial pleading must contain a certificate of the attorney or claimant that such reasonable inquiry resulted in a good faith belief that grounds exist for a lawsuit against each named defendant.

Under current law, a good faith belief may be shown if the claimant or his attorney receives a written opinion from a similar health care provider that there appears to be evidence of medical negligence (see BACKGROUND). But it may instead be shown in some other ways. The bill instead requires that there be a written signed opinion from a similar health care provider in order to show the existence of good faith. It requires that the opinion include a detailed basis for the opinion.

The bill requires the claimant or his attorney to retain the original written opinion and attach a copy of it to the complaint, with the similar health care provider's name and signature removed.

The bill imposes the same good faith certificate requirement on defendants who file an apportionment complaint against another health care provider as applies to the plaintiff. (An apportionment complaint is a claim by a health care defendant in a medical malpractice lawsuit that another health care provider who the plaintiff did not make a defendant committed malpractice and partially or totally caused the plaintiff's damages. By filing the apportionment complaint, the defendant in essence adds the other health care provider as party to the plaintiff's malpractice lawsuit.)

Under the bill, if a plaintiff asserts a claim against a party added to the case by a defendant by an apportionment complaint, he is not required to make a reasonable inquiry and submit a certificate of good faith regarding such person.

The bill makes the health care provider who provides the opinion immune from liability unless it is shown he acted with malice.

By law, the court may impose sanctions if a certificate was not made in good faith (see BACKGROUND).

NOTICE OF LAWSUITS TO DPH AND INSURANCE DEPARTMENT (§ 3)

The bill requires that upon filing a medical malpractice case against certain health care providers, the plaintiff or his attorney mail a copy of the complaint to the DPH and the Insurance Department. The requirement applies to lawsuits filed against licensed physicians, chiropractors, naturopaths, dentists, podiatrists, optometrists, and psychologists.

The bill specifies that the receipt or review of a copy of a complaint may not be considered an investigation of the individual licensee by the DPH or any examining board.

Existing law requires that anyone who pays damages in any medical malpractice case notify DPH of the terms of the award or settlement and provide a copy of the award or settlement and the underlying complaint and answer, if any. The bill requires that the notification specify, the portion attributable to economic damages and, if determined by the parties, the portion attributable to noneconomic damages. It also requires that (1) if there are multiple defendants, the

information include how the award must be allocated; and (2) the portion of the award, attributable to the offer of judgment law.

The bill (1) requires that the person who pays damages also to provide this information to the Insurance Department, (2) specifies that the copies provided to the Insurance Department may not identify the parties to the claim, and (3) requires that DPH send this information to the state board of examiners that oversees the health care provider who was a defendant in the lawsuit.

Under current law, DPH must review all medical malpractice awards and settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. The bill requires that DPH review all malpractice claims as well. It requires that, beginning October 1, 2004, DPH conduct its reviews in accordance with guidelines DPH adopts to determine the basis for such further investigation or disciplinary action.

The bill requires the DPH and insurance commissioners to develop systems within their respective agencies for collecting, storing, using, interpreting, reporting, and providing public access to the information they receive. It requires each commissioner to report the details of such systems within its agency to the Public Health and Insurance and Real Estate committees by October 1, 2004.

Release of Liability

Under current law and practice, people receiving a settlement in a malpractice claim sign a liability release to the person or entity paying the settlement. The bill makes such releases in connection with malpractice claims against the health care providers invalid until the attorney for the entity making payment on behalf of a party or, if no such entity exists, the attorney for the party, files with the court an affidavit stating that he has provided the information the bill and law require to DPH and the Insurance Department. The requirement applies to claims against licensed physicians, chiropractors, naturopaths, dentists, podiatrists, optometrists, and psychologists.

DPH INVESTIGATION GUIDELINES CONCERNING COMPLAINTS AGAINST PHYSICIANS (§ 4)

By law, the DPH commissioner, with the Connecticut Medical

Examining Board's advice and assistance, may establish regulations to carry out its oversight and regulatory duties. The bill requires the commissioner, by July 1, 2004, to adopt regulations that establish

1. guidelines for screening complaints that physicians may be unable to practice medicine with reasonable skill and safety to determine which complaints will be investigated;
2. guidelines to provide a basis for prioritizing the order in which complaints will be investigated;
3. a system for conducting investigations to ensure prompt action when it appears necessary;
4. guidelines to determine when an investigation should be broadened beyond the initial complaint to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations, and additional interviews of patients and peers; and
5. guidelines to protect and ensure the confidentiality of patient and provider identifiable information when an investigation is broadened beyond the initial complaint.

DISCIPLINARY GUIDELINES AND HEARING PROCEEDINGS AGAINST DOCTORS (§ 5)

The 15-member Connecticut Medical Examining Board is empowered to restrict, suspend, or revoke the license of a physician or limit his right to practice for certain misconduct.

The bill requires that, by July 1, 2004, the board, with DPH's assistance, adopt regulations that establish guidelines for use in the disciplinary process. The guidelines must include, but need not be limited to (1) identification of each type of violation; (2) a range of penalties for each type of violation; (3) additional optional conditions that the board may impose for each violation; (4) identification of factors the board must consider in determining if the maximum or minimum penalty should apply; (5) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (6) a provision that when a deviation from the guidelines occurs, the reason for the deviation must be identified.

By law, the board must refer all statements of charges DPH files with it to a medical hearing panel within 60 days of receiving them. Also by

law, the panel must conduct a hearing on contested cases. The panel must file a proposed final decision with the board within 120 days of receiving the notice of hearing by the board. The board may, for good cause, vote to extend both of these deadlines.

Under current law, the three-member medical hearing panel must include a board member and a public member. The bill requires instead that one member must be a similar health care provider, as defined by law, to the person who is the subject of the complaint, and two must be public members. It also requires that at least one of the three members be a member of the Connecticut Medical Examining Board. The public members may be members of the board or selected from the list of 18 people established by the public health commissioner.

The bill requires the DPH commissioner to conduct the hearing if the panel has not done so within 60 days of the date of referral of the statement of charges by the board. The hearing must be conducted in accordance with the regulations the commissioner adopts concerning contested cases. The bill requires the commissioner to file a proposed final decision with the board within 60 days after the hearing. The board, for good cause, may extend the filing deadlines in a recorded vote. The bill does not specify whether the board must accept the commissioner's decision.

DPH ANNUAL REPORTS OF DISCIPLINARY ACTIVITIES (§ 6)

By law, DPH must file with the governor and Public Health Committee an annual report of its disciplinary activities, which must include certain information. The bill requires that the report specify (1) the number of petitions and lawsuit notices not investigated and the reasons why, (2) the outcome of the hearings held on such petitions and notices, and (3) the timeliness of action taken on petitions and notices considered to be a priority.

PRE-SURGICAL PROTOCOLS (§7)

The bill requires DPH to develop protocols for accurate identification procedures that hospitals and outpatient surgical facilities must use before surgery. The protocols must include (1) procedures to be followed to identify the patient, surgical procedure to be performed, and body part on which the surgical procedure is to be performed; and

(2) alternative identification procedures in urgent or emergency circumstances or where the patient is nonspeaking, comatose, incompetent, or a child. After October 1, 2004, no hospital or outpatient surgical facility may anesthetize a patient or perform surgery unless the protocols have been followed.

The bill requires that, by October 1, 2004, DPH must report to the public health committee describing the protocols developed.

OFFER OF JUDGMENT BY PLAINTIFFS (§ 8)

Under current law, the plaintiff in a contract case or a case seeking money damages may, up to 30 days before trial, file with the court clerk a written "offer of judgment" offering to settle the claim for a specific amount. After trial, the court must examine the record to determine whether the plaintiff made an offer of judgment, which the defendant failed to accept. If it determines that the plaintiff recovered an amount equal to or greater than the sum stated in the plaintiff's offer of judgment, the court must add 12% annual interest.

By law, a defendant has 60 days to file with the clerk an acceptance of the offer. The bill allows the court to grant the defendant one or more extensions of up to 120 additional days to file an acceptance.

The bill changes the interest rate the court may award with respect to an offer of judgment for medical malpractice causes of action that accrue after the bill's effective date. It does so by reducing (1) from 12% to 8% the interest the court must add to the portion of the award up to twice the amount stated in the offer of judgment and (2) from 12% to 4% the interest the court must add to the portion of the award that exceeds twice the amount stated in the offer of judgment.

OFFER OF JUDGMENT BY DEFENDANTS (§ 9)

By law, in any contract case or a case seeking money damages, the defendant may, up to 30 days before trial, file a written offer of judgment with the court clerk offered to settle the case for a specific amount. The bill gives the plaintiff 60 instead of 10 days after being notified by the defendant of his offer to accept it. It also authorizes the court to grant the plaintiff one or more extensions up to 120 additional days for good cause. By law, unless the plaintiff recovers more than the offer of judgment, he must pay the defendant's costs accruing after

he received the offer including reasonable attorney's fees up to \$300.

NOTICE TO PETITIONER AND PHYSICIAN OF NO PROBABLE CAUSE FINDING (§ 10)

The law requires DPH to investigate each petition filed with it to determine if probable cause exists to issue a statement of charges and institute proceedings against the physician.

The bill requires DPH to notify the physician and person who filed a petition or his legal representative when it makes a finding of no probable cause. It must include the reason for such finding.

DPH DATA REGARDING PRACTITIONERS (§ 11)

By law, each person holding a license to practice medicine, surgery, podiatry, chiropractic or naturopathy must register annually with DPH and provide his name, residence, and business address, and other information DPH requests. The bill requires the licensee also to provide the name of the insurance company providing his malpractice insurance and the policy number, his area of specialization, whether he is actively involved in patient care, and any disciplinary action against him or malpractice payments made on his behalf in any other state or jurisdiction. The bill authorizes DPH to compare the information submitted to information contained in the National Practitioner Data Base.

The bill allows doctors to fulfill their obligation to report this information required by submitting it as part of their physician profile, as required by law. The bill requires DPH to revise any forms used for physician profiles to incorporate any additional required information.

NUMBER OF PHYSICIANS (§ 12)

The bill requires DPH, beginning January 1, 2005, and to report annually to the Senate and House clerks, the state librarian, and the Office of Legislative Research the number of physicians, by specialty, actively providing patient care in Connecticut.

PRIOR RATE APPROVAL (§ 13)

The bill subjects malpractice insurance rates for physicians and

surgeons, hospitals, advanced practice registered nurses, or physician assistants to prior rate approval by the insurance commissioner. On and after the bill's effective date, each insurer or rating organization seeking to change its rates for such insurance must file a request for such change with the Insurance Department and send written notice to all affected insurers.

The bill requires the insurer or rating organization to demonstrate in the filing, to the commissioner's satisfaction that (1) it offers a premium reduction or a separate reduced rating classification for insureds who submit proof that the insured and its personnel will use an electronic health record system during the premium period to establish and maintain patient records and verify patient treatment and (2) the premium or rate reduction reflects the reduction in risk related to the use of such system.

As an alternative, if the insurer or rating organization does not offer such premium or rate reduction, it must demonstrate to the commissioner's satisfaction that there is no measurable reduction in risk related to the use of such system.

They must file the request and send the notice at least 60 days before the change's effective date. Any request for a rate increase must be filed after notice is sent to insureds and must indicate the date the notice was sent. The notice must indicate that the insured may request a public hearing by submitting a written request to the insurance commissioner within 15 days after the date of the notice.

The bill prohibits the insurance commissioner from approving, modifying, or denying a rate increase until at least 15 days after the date of notice as indicated in the filing. It requires the commissioner to hold a public hearing, if requested, on an increase before acting. The bill requires the commissioner to approve, modify, or deny the filing within 45 days after its receipt. The commissioner's decision may be appealed to Superior Court.

MALPRACTICE RATES (§14)

The bill requires that insureds and the commissioner consider relevant factors that may reduce rates when establishing malpractice rates for physicians and surgeons, hospitals, or advanced practice registered nurses and physician assistants, including (1) amendments to the offer

of judgment law the bill makes, (2) other provisions of the bill, and (3) any reduction in risk from the use of electronic patient health record systems to establish and maintain patient records and verify patient treatment.

CONTINGENCY FEE WAIVER (§ 15)

Current law establishes a sliding scale on contingency fees attorneys may charge clients. It establishes an upper limit on contingency fees attorneys may collect from their clients based on the amount of the settlement or judgment. It allows (1) 33¹/₃% of the first \$300,000, (2) 25% of the next \$ 300,000, (3) 20% of the next \$300,000, (4) 15% of the next \$300,000, and (5) 10% of amounts exceeding \$1,250,000. This sliding scale applies to any lawsuit to recover damages resulting from personal injury, wrongful death, or property damage involving contingency fees, not just to medical malpractice cases. A Superior Court judge interpreted this law to allow clients to waive its protections and agree to pay a higher contingency fee (see BACKGROUND).

The bill invalidates a contingency fee arrangement with an attorney regarding a medical malpractice claim greater than the sliding scale's percentage limitations unless the claimant's attorney files an application with the court for approval, and the court, after a hearing, grants the application. The bill prohibits the court from approving a contingency fee greater than 33 1/3% of the damages awarded.

The bill requires the claimant's attorney to attach to the application a copy of the fee arrangement and the proposed unsigned writ, summons, and malpractice complaint. The fee arrangement must provide that (1) the attorney will advance all costs in connection with the investigation and prosecution or settlement of the case and (2) the claimant will not liable for the reimbursement for any such costs if there is no recovery.

The bill requires that at the hearing the court address the claimant personally to determine if he understands his rights and has knowingly and voluntarily waived them.

The bill requires the court to grant the application if it finds that (1) the case is sufficiently complex, unique, or different from other medical malpractice cases so as to warrant a deviation from the percentage

limitations and (2) the claimant knowingly and voluntarily waived his rights to the statutory fee schedule. At the hearing, the claimant's attorney has the burden of showing that the deviation is warranted.

If the court denies the application, it must advise the claimant of his right to seek representation by another attorney willing to abide by the percentage limitations. The court's decision to grant or deny the application may not be appealed. The filing of such application tolls the applicable statute of limitations until 90 days after the court's decision to grant or deny the application. The bill permits only one application to be filed regarding the claimant and his case.

The bill requires the chief court administrator to assign a judge or judges with experience in personal injury cases to hear and determine these applications. A hearing transcript must be prepared. It must be sealed and is available for the court's use only.

The bill prohibits an attorney from requiring a claimant to pay interest on the amount of any disbursements and costs the attorney makes in connection with investigating, prosecuting, or settling the malpractice claim.

Method by Which Fee is Calculated

For medical malpractice contingency fee arrangements, the bill requires that the percentages that go to the client and to the attorney be calculated after deducting any disbursements or costs the attorney incurred, other than ordinary office overhead and expenses.

MEDICAL MALPRACTICE DATA BASE—CLOSED CLAIM REPORTS (§ 16)

Current law authorizes the insurance commissioner to require all companies writing medical malpractice insurance in Connecticut to submit whatever information she deems necessary to establish a database on medical malpractice. The database may include information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved, and any other information relating to risk management.

The bill instead requires, beginning January 1, 2005, each insurer to provide to the commissioner with a closed claim report, on whatever

form she requires. A “closed claim” is a claim that has been settled, or otherwise disposed of, where the insurer has paid all claims. The duty to report applies to a captive insurer or a self-insured person.

The bill requires the insurer to submit the report within 10 days after the last day of the calendar quarter in which a claim for recovery under a medical liability policy is closed. The report must include information only about claims settled under Connecticut's laws. It must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid on the claim.

Details About the Insured and Insurer

The report must include the (1) insurer's name, (2) professional liability insurance policy limits and whether it was an occurrence policy or was issued on a claims-made basis; (3) insured's name, address, health care provider professional license number, and specialty coverage; and (4) insured's policy number and a unique claim number.

Details About the Injury or Loss

The bill requires that the report specify the (1) date of the injury or loss that was the basis of the claim; (2) date the injury or loss was reported to the insurer; (3) name of the institution or location where the injury or loss occurred; (4) type of injury or loss, including a severity of injury rating that corresponds with the injury scale that the commissioner must establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (5) name, age, and gender of any injured person covered by the claim.

Any individually identifiable information (as defined in 45 CFR 160.103), is confidential. The bill specifies that reporting of this information is required by law. It requires that if necessary to comply with federal privacy laws, the insured must arrange with the insurer to release the required information

Details About the Claims Process

The bill specifies that details about the claims process include (1) whether a lawsuit was filed, and if so, in which court; (2) the outcome of the lawsuit; (3) the number of other defendants, if any; (4) the stage in the process when the claim was closed; (5) the trial dates; (6) the

date of the judgment or settlement, if any; (7) whether an appeal was filed, and if so, the date filed; (8) the resolution of the appeal and the date such appeal was decided; (9) the date the claim was closed; and (10) the initial and final initial indemnity and expense reserve for the claim.

Details About the Amount Paid on the Claim

The bill specifies that details about the amount paid on the claim include

1. the total amount of the initial judgment rendered by a jury or awarded by the court;
2. the total amount of the settlement if there was no judgment rendered or awarded;
3. the total amount of the settlement if the claim was settled after judgment was rendered or awarded;
4. the amount of economic damages, or the insurer's estimate of the amount in the event of a settlement;
5. the amount of noneconomic damages, or the insurer's estimate of the amount in the event of a settlement;
6. the amount of any interest awarded due to failure to accept an offer of judgment;
7. the amount of any remittitur or additur;
8. the amount of final judgment after remittitur or additur;
9. the amount paid by the insurer;
10. the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits;
11. the amount paid by other insurers;
12. the amount paid by other defendants;
13. whether a structured settlement was used;
14. the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and
15. any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to medical professionals and entities, ensure the industry's solvency, and ensure that such liability insurance is available and affordable.

The bill requires the commissioner to establish an electronic database composed of closed claim reports.

Annual Data Summary

The bill requires the insurance commissioner to compile the data included in individual closed claim reports into an aggregated, summary format and prepare a written annual report of the summary data. The report must provide an analysis of closed claim information, including (1) a minimum of five years of comparative data, when available; (2) trends in frequency and severity of claims; (3) itemization of damages; (4) timeliness of the claims process; and (5) any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

The bill requires the annual report to include a summary of rate filings for medical malpractice insurance for medical professionals and entities that the department approved for the prior calendar year. The summary must include an analysis of the trend of direct losses, incurred losses, earned premiums, and investment income as compared to prior years. The report must also include base premiums charged by medical malpractice insurers for each specialty and the number of providers insured by specialty for each insurer.

The bill requires that, beginning March 15, 2006, and annually thereafter, the commissioner must submit an annual report to the Insurance and Real Estate Committee. She must also (1) make the report available to the public, (2) post it on the department's Internet site, and (3) provide public access to the contents of the electronic database after establishing that the names and other individually identifiable information about claimants and practitioners have been removed.

The bill requires the insurance commissioner to provide the DPH commissioner with electronic access to all the closed case information she receives.

PATIENT SAFETY PROGRAMS WITHIN DPH (§ 17)

The bill requires the DPH commissioner to develop and implement a process to ensure a continuing and coordinated focus on patient safety programs in DPH. The process must encompass activities DPH undertakes to (1) coordinate state patient safety initiatives; (2) facilitate ongoing collaborations between the public and private sectors; (3)

promote patient safety through education of health care providers and patients; (4) assure coordination in collecting, analyzing, and responding to adverse events reports; (5) coordinate state and federal patient safety programs; (6) participate in the federal Patient Safety Improvement Corps to identify the causes of medical errors; and (7) promote the recommendations of the Quality of Care Advisory Committee.

The bill requires that, by January 1, 2005, and annually thereafter, the DPH commissioner submit a report to the governor and the chairpersons of Public Health Committee describing the process developed, an analysis of its operation and impact with respect to the activities specified above, a description of the activities undertaken by DPH's patient safety programs, and recommendations for future action.

MANDATORY REVIEW OF NONECONOMIC DAMAGES EXCEEDING \$ 1,000,000 (§ 18)

The bill requires the court, in any medical malpractice case in which the jury awards more than \$ 1,000,000 in noneconomic damages, to review the evidence to determine if the amount of noneconomic damages is excessive as a matter of law. Specifically, the bill requires the court to consider whether it so shocks the sense of justice as to compel the conclusion that the jury was influenced by partiality, prejudice, mistake, or corruption. If the court concludes the award was excessive, it must order the plaintiff to remit the excessive amount. If the plaintiff refuses to do so, the court must set aside the verdict and order a new trial.

TAX CREDIT FOR CERTAIN PHYSICIANS (§19)

The bill gives any physician who is a state resident and subject to the state income tax for any taxable year the right to a credit in determining the amount of income tax liability for a portion of the amount of medical malpractice insurance premiums first becoming due and actually paid during the taxable year. The credit applies to tax years beginning January 1, 2004.

The credit equals 100% of the amount by which the premiums paid during the taxable year exceed 25 % of his Connecticut taxable income. But the credit may not exceed an amount equal to 15% of the

premiums.

The credit may only be used to reduce the taxpayer's tax liability for the year for which it applies, and may not be used to reduce the tax liability to less than zero.

The bill requires that the amount of income tax due must be calculated without regard to this credit.

The bill makes any physician who has ever had a medical malpractice judgment entered against him ineligible for the credit.

SOURCE OF FUNDS FOR TAX CREDIT (§20)

Under current law, notwithstanding any provision of the general statutes, for the fiscal year ending June 30, 2004, and the fiscal year ending June 30, 2005, the sum of \$2,000,000 shall be transferred from the resources of the Biomedical Research Trust Fund and credited to the resources of the General Fund. Under the bill, for the fiscal year ending June 30, 2005, any necessary portion of this sum is allocated to offset the revenue loss resulting from the tax credit the bill establishes.

CAPTIVE INSURERS (§§ 21 AND 22)

A "captive insurer" is an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies. In the case of groups and associations, it is an insurance organization owned by the insureds whose exclusive purpose is to insure risks of member organizations and group members and their affiliates.

The bill requires that each captive insurer that offers, renews or continues insurance in Connecticut provide the following information to the Insurance Commissioner in the same manner required for risk retention groups:

1. A copy of the group's financial statement submitted to its state of domicile, which must be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist;
2. a copy of each examination of the captive as certified by the

- commissioner or public official conducting the examination;
3. upon request by the commissioner, a copy of any audit performed with respect to the captive, and
 4. such information as may be required to verify that it satisfies the definitional requirements of a risk retention group (apparently this requirement only applies if the captive is an RRG).

If a captive insurer does not maintain this information in this form the bill permits the captive insurer to submit the information to the Insurance Commissioner on whatever form the commissioner prescribes. The bill specifies that these requirements do not apply to a captive insurer that is otherwise required by law to submit such information to the commissioner.

The bill requires the insurance commissioner to act as agent for service of process for risk retention groups domiciled outside the United States and for captive insurers. By law, the commissioner acts as agent for risk retention groups domiciled in some other state in the United States and offering insurance in this state.

ELIMINATION OF MALPRACTICE SCREENING PANEL (§ 23)

The bill eliminates the voluntary Medical Malpractice-Screening Panel. Under current law, the parties must consent to use the panel. In accordance with their mutual agreement, the insurance commissioner or her designee selects panel members from lists of names submitted by the Connecticut State Medical Society and the Connecticut Bar Association. The panel is composed of two doctors and one attorney with trial experience in personal injury cases who acts as chairman. One of the doctors must practice in the same specialty as the defendant. Panel members cannot be from communities in which the defendant doctor or the parties' attorneys practice. Panel members are not compensated. The panel holds confidential hearings when and where it decides and transcripts are available at cost to either party.

The panel's conclusion as to liability is outlined in a finding signed by the members and recorded by the insurance commissioner. The panel does not address the issue of damages. Each party receives a copy of the panel's findings. If a subsequent trial is held, only unanimous findings of the panel are admissible. The court or jury determines the weight assigned to such admissible findings. No member can be compelled to testify.

BACKGROUND

Related Bills

sSB 60 (File 165) makes numerous changes to tort law; insurance regulation; and the oversight, regulation, and discipline of doctors. It is very similar to sSB 394, but sSB 394 contains provisions for a fund to pay for malpractice insurance deductibles.

sSB 61 (File 166) establishes a fund to reimburse a portion of a malpractice claim, settlement, or judgment, which represents the deductible portion applicable to a provider's coverage. It authorizes the insurance commissioner to approve policies that contain deductibles up to \$ 50,000 for an individual and \$ 100,000 for a hospital. It establishes another fund that pays a portion of a malpractice award or settlement that exceeds certain amounts. The maximum amount the fund may pay per claim is \$ 500,000.

SB 141 (File 132) is based on the committee's investigation and report. The bill makes numerous changes to tort law, insurance regulation, and disciplining of health care providers. Tort reform provisions deal with such areas as offers of judgment, mediation, attorney's fees, elimination of the screening panel, and establishing a task force to study alternatives to a tort system. Insurance provisions include prior rate approval, data gathering, and captive insurers.

Other provisions deal with investigatory complaints against doctors, the complaint investigation process and standards, data gathering, mandatory continuing education for doctors, and a task force to examine the feasibility of developing a doctor relicensing exam.

sSB 356 (File 431) makes numerous changes to tort law; insurance regulation and oversight; and the regulation, oversight, and discipline of medical providers. It is similar in many respects to SB 60, sSB 394, and sHB 5669. It makes the malpractice screening panel mandatory and does not require that the panel's findings be mandatory to be admissible in malpractice trials. It establishes a fund to pay the deductible portion of a malpractice premium up to certain limits. The fund is supported by assessments on malpractice awards or settlements. It is on the Senate calendar.

sSB 394 (File 186) makes numerous changes to tort law; insurance regulation; and the oversight, regulation, and discipline of doctors. It is very similar to sSB 60 except it contains a provision for a fund. The insurance provisions relate to prior rate approval, captive insurers, data collection, and the requirement of certain companies to offer malpractice insurance. It establishes surgery protocols, electronic medical records, and investigation of doctors.

sSB 566 revises the law requiring hospital and outpatient surgical facilities to report adverse events to DPH. It allows DPH to designate as a "patient safety organization" a public or private organization whose primary mission involves patient safety improvement activities.

"Similar Health Care Provider"

By law, if the defendant health care provider is not certified by the appropriate American board as a specialist, is not trained and experienced in a medical specialty, or does not hold himself out as a specialist, a "similar health care provider" is one who is (1) licensed by the appropriate regulatory agency of this state or another state requiring the same or greater qualifications and (2) trained and experienced in the same discipline or school of practice. Such training and experience must be a result of active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.

If the defendant health care provider is certified by the appropriate American board as a specialist, is trained and experienced in a medical specialty, or holds himself out as a specialist, a "similar health care provider" is one who is (1) trained and experienced in the same specialty and (2) certified by the appropriate American board in the same specialty. But, if the defendant health care provider is providing treatment or diagnosis for a condition that is not within his specialty, a similar health care provider is a specialist trained in the treatment or diagnosis for that condition.

Sanctions if Certificate not Filed in Good Faith

By law, the court must impose an appropriate sanction upon the person who signed the certificate if it determines, after the completion of discovery, that the certificate was not made in good faith and that no valid issue was presented against a health care provider that fully

cooperated in providing informal discovery. It may also impose the sanction on the claimant. The sanction may include an order to pay to the other party or parties the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee. The court also may submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney submitted the certificate.

Attorney Fees

Table 1 shows how the statutory formula under current law works for each of four hypothetical awards. It shows the actual amount of fees the statute allows the attorney to collect, the resulting percentage of the total award the attorney's fees constitute, the amount the client would receive, and the resulting percentage the client receives.

Table 1: Attorney's Fees for Various Damage Awards

Damage Award or Settlement	Contingency Fee the Law Allows	Percentage of Total Award to Attorney	Amount Client Receives	Percentage of Total Award to Client
\$ 100,000	\$ 33,333	33.33%	\$ 66,667	66.67%
\$ 500,000	\$ 150,000	30%	\$ 350,000	70%
\$ 1,000,000	\$ 250,000	25%	\$ 750,000	75%
\$ 5,000,000	\$ 660,000	13.2%	\$ 4,540,000	86.8%
\$ 10,000,000	\$ 1,160,000	11.6%	\$ 8,840,000	88.4%

Waiver of Fee Schedule

Current law does not explicitly indicate whether a client can waive the contingency fee limits that the statute imposes. One Superior Court case held that tort victims could waive their right to the protections afforded by the contingency fee law. The court also decided the plaintiff's waiver was valid, and the fee arrangement the plaintiff entered into with her attorney was reasonable (*In re Estate of Salerno*, 42 Conn. Supp. 526 (1993)).

The court resolved the case on nonconstitutional grounds, noting that rights granted by statute could be waived unless the statute is meant to protect the general rights of the public rather than private rights. It

cited instances where statutes relating to litigation have been construed as conferring a private right that can be waived (e. g. , statute of limitations for tort actions, right to trial by jury, defense of statute of fraud).

It concluded that the fee cap statute clearly confers a private right and does not protect the general rights of the public. It also cited the legislative history in which proponents of the law indicated that the fee limits could be waived.

Complaints Against Doctors Filed With DPH

A person may file a petition against a doctor for the same reasons the Medical Examining Board may discipline a doctor. These include:

1. physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process;
2. emotional disorder or mental illness;
3. abuse or excessive use of drugs or alcohol;
4. illegal, incompetent, or negligent conduct in the practice of medicine;
5. possession, use, prescription for use, or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes;
6. misrepresentation or concealment of a material fact in the obtaining or reinstatement of a license to practice medicine;
7. failure to adequately supervise a physician assistant;
8. failure to fulfill any obligation resulting from participation in the National Health Service Corps;
9. failure to maintain required professional liability insurance or other indemnity against liability for professional malpractice;
10. failure to provide information DPH requests to complete a health care provider profile;
11. performing any activity for which accreditation is required by law without appropriate accreditation required;
12. failure to provide evidence of accreditation required by law as requested by DPH; and
13. violation of any law regulating medicine and surgery or any regulation adopted under such laws.

Physician Profiles

The law requires DPH, in consultation with the Connecticut Medical Society and the State Medical Examining Board, to develop profiles of state-licensed physicians, and make them available to the public. The profile must contain information about their education, practice, and certifications; medical malpractice claims and settlements; disciplinary actions; criminal convictions; hospital privileges; and other information. DPH must also study adding additional health care providers to the profile system.

Education and Practice Information. The profiles must contain information about the physician's medical education and practice including (1) his medical school and graduation date; (2) the site, training, discipline and dates of postgraduate medical education; (3) practice specialty; (4) the address of his primary practice location; (5) the languages, other than English, spoken at the practice; (6) current certification issued by a specialty board of the American Board of Medical Specialties; (7) the hospitals and nursing homes where he has privileges; (8) appointment to Connecticut medical school faculties and other responsibilities for graduate medical education; (9) a list of publications in peer-reviewed literature; and (10) a list of professional services, activities, and awards.

A physician must notify DPH of any changes in the information about practice specialty, primary practice address, languages spoken, current certifications, hospital and nursing home privileges, and criminal convictions (see below) within 60 days of the change.

Disciplinary Actions. The profile must indicate any disciplinary actions taken against the physician by DPH or the Connecticut Medical Examining Board. It must also include any hospital disciplinary actions taken against the physician in the past 10 years resulting in (1) termination or revocation of his privileges for a medical disciplinary reason, (2) resignation from or nonrenewal of medical staff membership, or (3) restriction of privileges in lieu of or in settling a pending disciplinary case related to medical competence.

Criminal Convictions. The profile must contain a description of criminal convictions for felonies within the last 10 years. Conviction of a felony means the physician pleaded guilty, was found guilty by a court, or was convicted of a felony from a plea of no contest.

Medical Malpractice Claims. The profile must contain, to the extent

available, all medical malpractice court judgments, arbitration awards, or settlements against the physician where payment was made during the last 10 years. Any reports of judgments or awards must comply with the following: (1) paid claims must be reported in at least three graduated categories of level of award significance; (2) information on an individual physician's paid judgments, awards, and settlements must be compared with other state physicians performing procedures with a similar degree of risk; (3) all judgment and settlement information must be limited to actual amounts paid by or for the physician; and (4) comparisons of malpractice data must include (a) an explanation that physicians doing certain procedures or treating certain patients are more likely to be sued and that the comparison is for physicians with a similar degree of risk, (b) a statement that the report covers the last 10 years and that consumers should consider the physician's total years of practice, (c) an explanation that the incident causing the malpractice claim may have happened years before any payment was made because of the workings of the legal system, (d) an explanation of the effect of treating high-risk patients on a physician's malpractice history, and (e) an explanation that cases may be settled for other than liability reasons and are sometimes settled by the insurer without the physician's consent.

INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Individually identifiable health information is defined by federal regulation (45 CFR 160.103) as information that is a subset of health information, including demographic information collected from an individual, and:

1. is created or received by a healthcare provider, health plan, employer, or health care clearinghouse; and
2. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (a) that identifies the individual; or (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Risk Retention Group

“Risk retention group” means any corporation or other limited liability association: (1) whose primary activity consists of assuming and

spreading all, or any portion, of the liability exposure of its group members; (2) which is organized for the primary purpose of conducting such activity; (3) which (a) is chartered and licensed as a liability insurance company under the laws of a state and authorized to engage in the business of insurance under the laws of such state or (b) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group must be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the Product Liability Risk Retention Act of 1981, (15 USC 3901 et seq.), before the date of the enactment of the Liability Risk Retention Act of 1986; (4) which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person; which (a) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group or (b) has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group, and as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; (5) whose members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; (6) whose activities do not include the provision of insurance other than (a) liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its group members and (b) reinsurance with respect to the similar or related liability exposure of any other risk retention group, or any member of such other group, which is engaged in businesses or activities so that such group or member meets the requirement described above for membership in the risk retention group which provides such reinsurance; and (7) the name of which includes the phrase "Risk Retention Group" (CGS § 38a -250(11)).

Legislative History

The House referred the bill (1) to the Appropriations Committee on

April 13, which reported it unchanged on April 20; (2) to the Public Health Committee on April 21, which reported it unchanged on out unchanged on April 21; and (3) to the Finance, Revenue and Bonding Committee on April 22, which reported it unchanged on April 22.

COMMITTEE ACTION

Judiciary Committee

Joint Favorable Substitute
Yea 41 Nay 1

Appropriations Committee

Joint Favorable Report
Yea 50 Nay 0

Public Health Committee

Joint Favorable Report
Yea 22 Nay 0

Finance, Revenue and Bonding Committee

Joint Favorable Report
Yea 40 Nay 0